# CITY OF LONG BEACH HEALTH STATISTICS

Official Data for 1998 - 2000
Issued 2002

# A MESSAGE FROM THE DIRECTOR

As the Director of the City of Long Beach Department of Health and Human Services (Health Department) and a long-time resident of Long Beach, it is with pleasure that I present the City of Long Beach Health Statistics Report.

For over 96 years, the Health Department has played a vital role in shaping the health of our community. As a city-based Health Department, we feel a strong commitment to work in partnership with our community members to improve the quality of life for all Long Beach residents. The intention of this publication is to give you, our community partners, a picture of the overall health of Long Beach. This publication is one of the tools that the Health Department has developed to increase the awareness of health risks and begin to design programs and services that meet the needs of our diverse and dynamic population.

I hope that you will find the City of Long Beach Health Statistics Report informative and helpful. Let us move forward together to build a healthier community.

Thank you,

Ronald R. Arias, MPA

## OUR MISSION

The mission of the City of Long Beach Department of Health and Human Services is to improve the quality of life of the residents of Long Beach by addressing public health and human service needs, ensuring that the conditions affecting the public's health afford a healthy environment in which to live, work, and play.

Dear Colleagues:

On behalf of the City of Long Beach Department of Health and Human Services, we are pleased to present the City of Long Beach Health Statistics Report containing official data for 1998-2000.

This document focuses on a select group of indicators that address maternal, child and adolescent health, vital statistics, communicable diseases, and social and demographic characteristics. Age, gender and race/ethnicity composition of the health indicators is presented, with time trends and incidence rates, where available.

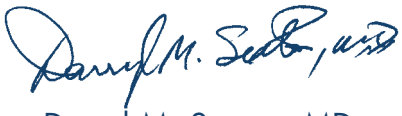
The City of Long Beach Health Statistics Report serves as a tool and a reference document for making decisions about policy, program development and grant applications. The epidemiological and vital statistics data presents a framework of relevant health information for use by health care providers, policy makers, educators, and other community members.

Since its inception in 1906, the vision of the Health Department has been to provide locally developed and implemented programs and services which reflect the City's diverse communities. Our programs will always focus on the promotion of wellness and the prevention of communicable diseases, but we will also evolve in the years ahead, as we monitor health trends. As we carry out our own strategic planning process, our commitment is to provide significant health and human services and programs, which have a demonstrable impact on the health of Long Beach residents.

Please use this report as a resource for the state of health in the City of Long Beach and share it with others who may benefit from the information. We look forward to continuing to work with you to improve the quality of life for all members of our diverse community.

Sincerely,

Ronald R. Arias, MPA
Director



Darryl M. Sexton, MD
City Health Officer

## CITY OF LONG BEACH HEALTH STATISTICS REPORT

The State Department of Health Services is responsible for directing and supervising the registration of vital records in California as prescribed by the Health and Safety Code, California Code of Regulations, Title 17, Section 2500. Through this mechanism, local data on births, deaths, and incidence of many communicable diseases are collected continually throughout the year. The time required by the State to validate local data and to report the data back to the local health jurisdictions results in delays in the development of publications such as this one. The City of Long Beach Health Statistics Report, issued July 2002, contains official data for 1998-2000, as available.

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# THE NATURE OF DISEASE SURVEILLANCE

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Disease prevention and health promotion are the primary goals of public health. Many elements contribute to the health of a community such as sociodemographic characteristics, healthy lifestyles, access to health care, disease trends, and environmental health. Using various data and information sources, in combination with input from City residents, community partners and professionals in various fields, the City of Long Beach Department of Health and Human Services (Health Department) takes the lead in identifying and prioritizing the public health needs for Long Beach. The Health Department is one of 61 health jurisdictions in the State of California and operates separately from the Los Angeles County Department of Health Services. By using local data as the foundation for the planning of disease prevention and health promotion activities, the Health Department helps to ensure a more targeted impact on improving the quality of life for the residents of Long Beach.

Much of the data presented in the City of Long Beach Health Statistics Report was collected by the Health Department and sent to the California State Department of Health Services and on to the Centers for Disease Control and Prevention. The Health and Safety Code, California Code of Regulations, Title 17, Section 2500, requires reporting of 81 diseases and conditions. All but three are communicable diseases. Through this mechanism, local data on births, deaths, and the incidence of many communicable diseases are collected throughout the year.

These data must be interpreted in light of reporting practices. Diseases that cause severe clinical illness such as AIDS, are most likely to be reported accurately. However, persons who have diseases that are clinically mild and infrequently associated with serious consequences such as viral meningitis, may not seek care from a health care provider. Even if these less severe diseases are diagnosed, they are less likely to be reported to the Health Department. Finally, factors such as changes in case definitions for public health surveillance, the introduction of new diagnostic tests, the discovery of new disease entities, or culturally influenced care seeking practices, may cause changes in disease reporting that are independent of the true incidence of disease. While the exact number of cases of a particular disease at any one time may be difficult to assess, these data limitations have been consistent over time. Therefore, trend data presented in this report are a reliable measure of disease burden over time.

Epidemiology, the population-based study of diseases and their distribution within a community, is an important part of the scientific public health foundation. Throughout the 20th century, improvements occurred in methods of data collection from simple measures of disease prevalence to complex studies of precise analysis.

Disease surveillance systems maintained by the Health Department provide for the ongoing collection, analysis, and dissemination of data to prevent and control disease. Public health professionals, health care providers, community leaders, educators, and community members may use the disease surveillance data presented in this report in numerous ways including:

- identify cases for investigation and follow-up;
- estimate the magnitude of a health problem and follow trends in its incidence and distribution;
- formulate and evaluate control and prevention measures;
- detect outbreaks or epidemics and generate appropriate interventions;
- monitor changes in infectious agents (e.g., antibiotic resistance, emerging infections);
- facilitate epidemiologic and laboratory research;
- detect changes in health practice (e.g., impact of use of new diagnostic methods on case counts); and
- facilitate planning (e.g., allocation of program resources, policy development).

# PUBLIC HEALTH:
# A CENTURY OF SUCCESS

# PUBLIC HEALTH: A CENTURY OF SUCCESS

As we begin a new millennium, public health can celebrate a century of achievements that have greatly impacted the nation's health. Accomplishments in the field of public health and medicine have enabled individuals to live longer and healthier lives. Although there have been many achievements in the 20th century, 10 major accomplishments have been singled out by the Centers for Disease Control and Prevention (CDC) as having the most importance to the progress of public health. The following selections of public health achievements from 1900 to 1999 in the United States were chosen based on the opportunity for prevention and the impact on death, illness and disability and are not ranked by order of importance.

## Vaccination

When few effective treatments and preventive measures were available, infectious diseases threatened large populations. In the 20th century, medicine and vaccines were developed to enable the control and prevention of infectious diseases. Because of immunization for vaccine preventable diseases, over 20 diseases can be prevented today. In 1977, smallpox infection was eradicated and polio is near eradication. These public health achievements are a result of effective vaccines, community awareness and prevention efforts. In the United States, diseases such as measles, diphtheria and tetanus are at record lows. A combination of timely vaccination of children, adolescents and adults and the efforts of community public health partners to promote immunization is needed to achieve even greater results in reducing and eradicating vaccine preventable infectious diseases.

## Motor Vehicle Safety

The invention of the automobile has created effective means of transportation, yet it has contributed to many modern problems such as traffic related injuries and death. Motor vehicle safety interventions, which include the use of safety belts, child safety seats, improved motor vehicle technology, and community awareness of motor vehicle safety laws, have contributed to safer driving conditions despite the greater number of drivers on the road traveling more miles at faster speeds.

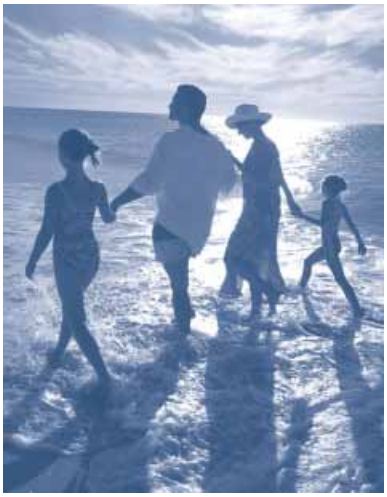
## Safer Workplaces

Over the course of the last century, the workplace transitioned from agricultural to industrial to technological. Improvements in workplace environmental health and safety standards have remarkably decreased the risk of injury and death for workers. Although the workforce in the United States tripled from the 1930's to the 1990's, identification and correction of occupational health hazards reduced the health and safety risks for many occupations, ranging from construction, mining and farming to medical laboratory technicians, engineers and computer operators. Employees, unions, employers, government agencies, and scientists have made significant efforts to create and promote safer working conditions so that workers may have a productive work experience and reduce the risk from the long-term consequences of occupational diseases and injuries.

## Control of Infectious Diseases

Improved sanitation and hygiene is considered one of the greatest medical achievements of the 20th century, and is responsible for saving more lives than all the drugs and medical procedures developed during the century combined (Los Angeles Times, 1999). The introduction and use of antibiotics and other antimicrobial drugs are also attributed to saving lives. These drugs have been in common use since the 1940's to treat streptococcal and staphylococcal infections, gonorrhea, syphilis, and many other bacterial, viral, fungal, and parasitic infections.

Early in the 20th century, the development of serologic testing and more recently, the development of molecular assays based on nucleic acid amplification and DNA probes have increased the capacity for detecting, diagnosing and monitoring infectious diseases. Technological changes such as computers and other forms of communication have also enhanced the ability to gather, analyze and disseminate communicable disease surveil lance data. These tools are important in controlling the spread of communicable diseases.



## Decline in Deaths From Coronary Heart Disease and Stroke

Since 1921, heart disease has been the leading cause of death, and since 1938 stroke has been the third leading cause of death in the United States. However, since 1950, age-adjusted death rates from cardiovascular disease (CVD) have declined 60%. A greater understanding of disease epidemiology and advances in prevention techniques, diagnoses and treatment are responsible for the decline in the age-adjusted death rate. Additionally, the understanding of the risk factor concept, the idea that particular biologic, lifestyle and social conditions are associated with increased risk for specific diseases, contributed to the development of population-based research into the causes of disease such as CVD. Studies demonstrated that reducing behavioral risks of CVD such as cigarette smoking, blood pressure levels, cholesterol levels, and obesity have resulted in positive trends that contributed to the decline in CVD. Prevention efforts and improvements in early detection, treatment and care have also resulted in fewer CVD related deaths.

## Safer and Healthier Foods

In the first half of the 20th century, contaminated food, milk and water were responsible for many food-and water-borne diseases, which contributed to the leading causes of death. Diseases such as typhoid fever, cholera, mycobacterium bovis, and botulism were among the most prevalent conditions caused by food-and water-borne pathogens. Chlorination of water and pasteurization of milk were notable discoveries that helped reduce the incidence of these diseases. Additionally, identification of the characteristics and sources of food-and water-borne pathogens led to technological improvements and safer food handling procedures including better sanitation, refrigeration and food processing.

## Healthier Mothers and Babies

Declines in maternal and infant mortality represent an important achievement in public health in the United States. At the beginning of the 20th century, the maternal mortality rate was between 6 to 9 women per 1,000 live births and approximately 100 infants per 1,000 live births died before the age of one. Since the early 1900's, maternal mortality and infant mortality have decreased 99% and 90%, respectively. Factors that have contributed to these declines are: early prenatal care, advanced clinical care, safer food, water and sewage disposal, better nutrition, improved living standards, improved medical technology, and increased educational levels.

## Family Planning

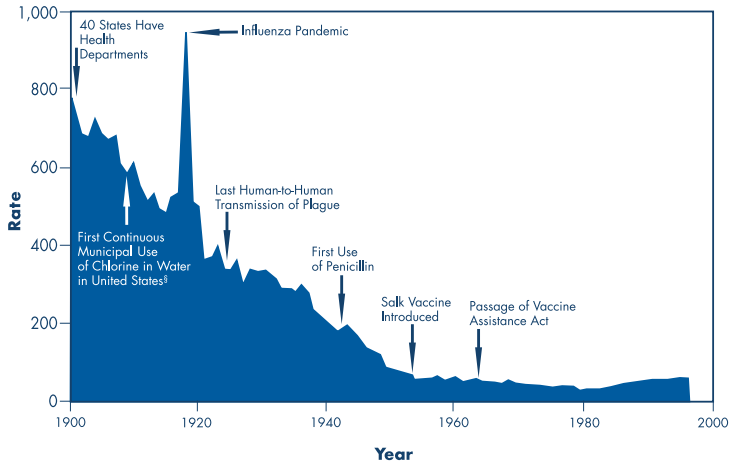
In the late 1800's and early 1900's, distribution of information regarding contraception and contraceptive devices was illegal in

the United States. However, changes in family planning during the course of the 1900's altered social and economic roles for women. Family planning has provided such benefits as smaller family size, longer intervals between the birth of children and decreased infant, child and maternal deaths.

## Fluoridation of Drinking Water

The prevalence of dental caries (tooth decay) was rampant throughout the nation for more than half of the 20th century. However, water fluoridation has proved to be a major advancement in the prevention of dental caries. In 1901, the relationship between drinking water and dental health was identified. In 1931, research was conducted to establish an association between fluoride and dental caries. In 1945, Grand Rapids, Michigan became the first city in the world to add fluoride to its drinking water. Children born after fluoride was added to the water supply had lower rates of dental caries. This finding is considered revolutionary in dental care and fluoride has become a standard form of prevention. Water fluoridation remains the most far-reaching and cost-effective method of delivering fluoride to communities.

**Figure 1: Crude death rate* for infectious diseases - United States, 1900 - 1996.†**




*Per 100,000 population per year.
†Adapted from Armstrong GL, Conn LA, Pinner RW. Trends in infectious disease mortality in the United States during the 20th century. JAMA 1999:281;61-6.
§American Water Works Association. Water chlorination principles and practices: AWWA manual M20. Denver, Colorado: American Water Works Association, 1973.

*Source: Centers for Diseases Control and Prevention. MMWR, 1999.*

## Recognition of Tobacco Use as a Health Hazard

Tobacco use has been recognized as the number one preventable cause of death and disability in the United States. Tobacco related conditions kill more people each year than the following health hazards combined: AIDS; alcohol and drug abuse; motor vehicle crash injuries; murders; and suicides. Although the per capita consumption rate of cigarettes decreased by nearly half from the early 1960's to 1998, increased prevention efforts are needed to further reduce the impact of tobacco use on public health. Measures that appear to be associated with the reduction in cigarette smoking and improved health outcomes are: 1964 Surgeon General's report, doubling of federal cigarette taxes, Master Settlement Agreement, no-smoking regulations in public places, and banning of tobacco advertising in many venues.

As a result of these and other public health achievements, health and life expectancy of persons in the United States improved significantly. People live approximately 30 years longer today than they did 100 years ago. Advances in public health are responsible for 25 of the nearly 30 years of improved life expectancy. Identifying emerging diseases, preventing chronic diseases, workforce training, addressing disparities among racial/ethnic populations, and strengthening community partnerships are public health issues that will result in future achievements and improved quality of life in the 21st century.

The Health Department has made significant contributions to improving the health and well-being of the community. The Health Department shares many of the Nation's public health achievements, including higher immunization rates, lower infant mortality rates, higher percentages of mother's receiving prenatal care in the first trimester, control of infectious diseases, safer environment, and tobacco education.

# LONG BEACH: A DIVERSE COMMUNITY

## Demographic Profile

The City of Long Beach is a community of which we can be proud. Its location along the Pacific Ocean, sunny skies and diversity make Long Beach the perfect place to live, work and play. Race/ethnicity are important determinants of health patterns in Long Beach and on a national level. More important are trend data by race/ethnicity, which sheds light on the process of change from one year to the next. Trend data evaluated by racial/ethnic background signals emerging problems or improvements in health status and are essential in evaluating interventions.

The population of Long Beach has grown steadily since the 1930's when the City was comprised of less than 30 square miles and had an estimated population of 142,032. Today, Long Beach is comprised of over 50 square miles in land area and has a population of 461,522. The "International City" or "Iowa by the Sea," as Long Beach was once known, is the fifth largest city in the State of California and the 34th largest in the Nation.

*Source: U.S. Bureau of the Census, Census 2000.*

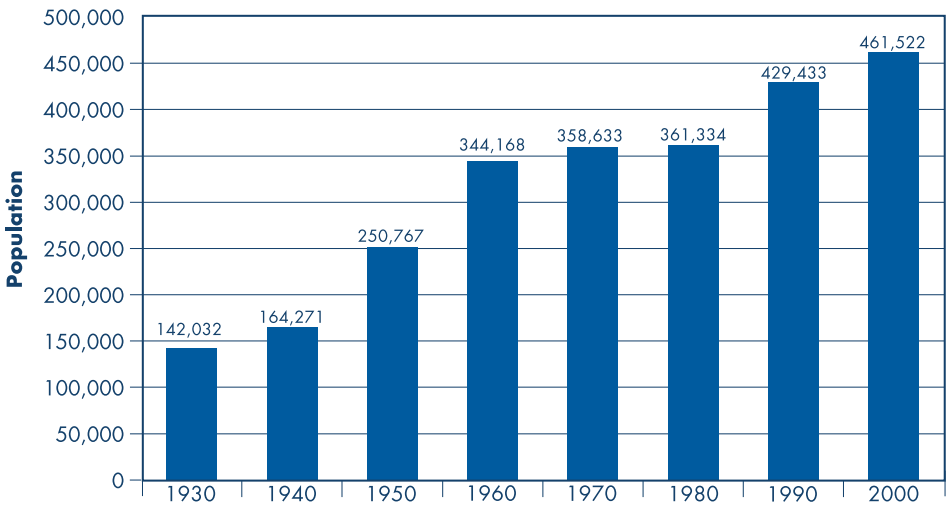
One of Long Beach's most important and attractive attributes is the diversity of its population. From 1990 to 2000, the population in Long Beach increased by 7.5%. In 2000, the U.S. Census Bureau recorded that there is no strong racial/ethnic majority in Long Beach. Hispanics make up 35.5% of the residents, with Whites, Blacks and Asian/Pacific Islanders making up 33.1%, 14.5% and 13.1%, respectively. The Black and Asian/Pacific Islander populations showed little percent change from the 1990 to the 2000 Census. The category of persons with two or more races was included for the first time in the 2000 Census. In the City of Long Beach, 2.9% of the population indicated they identify with two or more racial/ethnic groups.

In Long Beach, 55.8% of the population five years and over speak English only at home. Individuals who speak a language other than English at home comprise 44.2% of the population. Of the population that speaks a language other than English at home, 30.4% speak Spanish, 11.2% speak Asian and Pacific Island languages and 2.2% speak other languages.

Age is a powerful predictor of future health challenges in a community. The 2000 U.S. Census indicated that in Long Beach, the younger population aged birth to 19 years increased 22% from 1990. A 28% percent increase from 1990 to 2000 was seen in the middle-aged and older adults (ages 35 to 59). The 2000 U.S. Census showed slight decreases in the population of young adults aged 20 to 34 years and senior citizens aged 60 years and older from the 1990 Census. In 2000, the median age in Long Beach was 30.8 years.

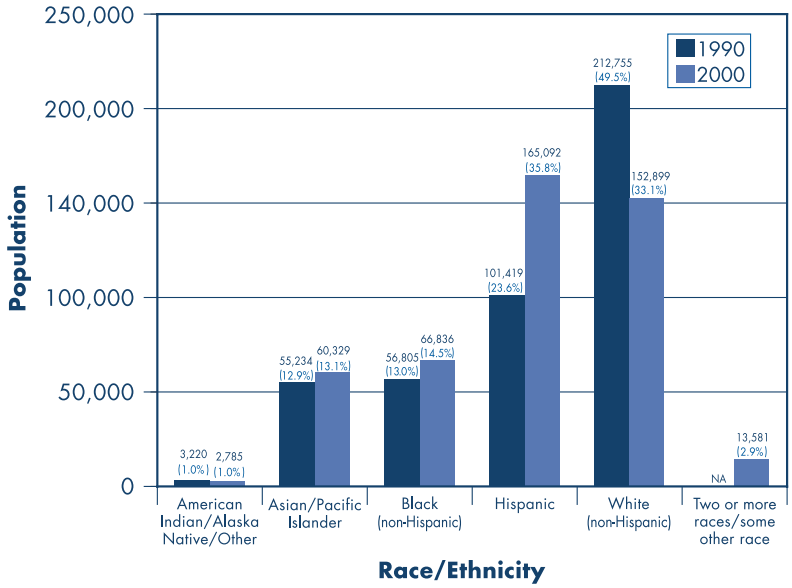
*Source: U.S. Bureau of the Census, Census 1990 and 2000.*

**Figure 2: Population by year, City of Long Beach, 1930-2000.**




Source: U.S. Census Bureau.

**Figure 3: Population distribution by race/ethnicity, City of Long Beach, 1990 and 2000.**




Total population in 1990 = 429,433
Total population in 2000 = 461,522
Source: U.S. Census Bureau.

A comparison of the changes in gender and age group breakdown from the 1990 to the 2000 U.S. Census is illustrated in the demographics section of the data appendices.

## Socio-Economic Status

Countless studies have documented the link between socio-economic status and health. Socio-economic status measures such as education, income, poverty level, and marital status, are important components that influence the health and quality of life for individuals and families. The effects of these socio-economic components and access to health care services all tend to operate together to influence health status, confounding the efforts to isolate the impact of any singular factor. Socio-economic status is linked to many different health outcomes such as chronic disease, tobacco use, being overweight and sedentary lifestyles, and adolescent pregnancy.

Based on the 2000 U.S. Census, 27.3% of the population in Long Beach 25 years and over do not have a high school diploma, 18.8% are high school graduates or equivalent, 30.0% have some college or an associate's degree, and 23.9% have a bachelor's degree or higher.

According to the Census Bureau, in 1999, the median household income in Long Beach was $37,270. Individuals and families living below the poverty level comprised 22.8% and 19.3%, respectively in 1999.

Additionally, the 2000 U.S. Census indicated that in Long Beach, 37.4% of the population aged 15 years and over are single and have never been married. The City is largely comprised of married individuals (43.1%), and 19.5% of the population is separated, widowed or divorced.

*Source: U.S. Bureau of the Census, Census 2000.*

# BIRTHS AND DEATHS

## Birth and Death Registration Process

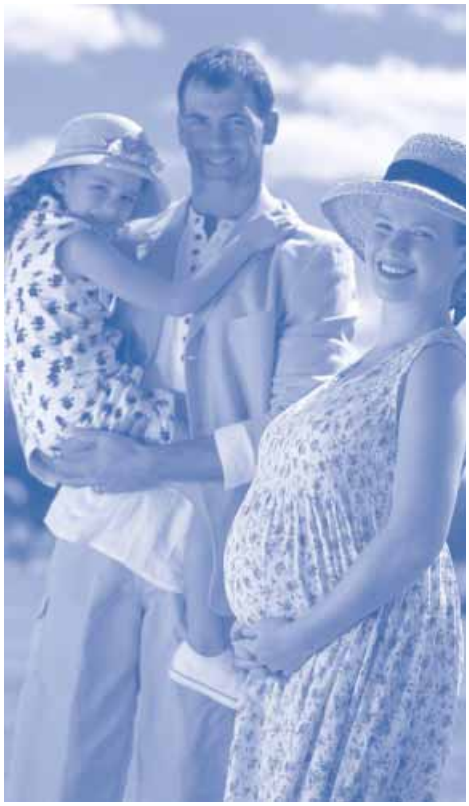
The California Vital Records System includes the collection, registration, maintenance, amendment, and certification of vital records, or births and deaths. The State Department of Health Services, Office of Vital Records is responsible for directing and supervising the registration of vital records in California. Under State supervision, each local registrar registers and transmits the original records for events occurring in the local jurisdiction to the State for filing and indexing. The State then transmits vital records statistical data to the National Center for Health Statistics at the CDC.

The vital records system was initially established to record births and deaths occurring in California. In addition to documenting these events, the statistical data derived from these records are used to develop a health status profile for the State. The purpose of the vital records system become twofold:

- to establish a permanent record that is legally recognized as prima facie evidence of the facts stated therein; and
- to provide a means for studying the statistical data for health evaluation and planning purposes.

## Births

In 1998 and 1999, the City of Long Beach registered 8,509 and 8,492 births, respectively. The crude birth rate was 19.8 births per 1,000 population in both 1998 and 1999, continuing a decreasing trend in births over the last decade. The crude birth rate is a measure of fertility and is highly correlated with typical family size. The Long Beach crude birth rate indicates that women typically bear two or three children in their lifetime. Among all races/ethnicities in Long Beach, Hispanic mothers comprised the majority of the births in 1998 and 1999, with 49.5% and 51.5%, respectively of all live births in the City. In the same time period, mothers between the ages of 18-29 years accounted for about 60% of the live births. The data appendices further illustrate the births in Long Beach in 1998 and 1999 by mother's age and race/ethnicity.



### *Maternal, Child and Adolescent Health*

There are many indicators by which maternal, child and adolescent health may be measured. However, even at the national level, there currently is no existing "child health surveillance system." Rather, data on these different indicators of children's health are collected separately; if evaluated as a whole, whether at the national or local level, we can begin to draw a clearer picture of children's health within the population being examined.

### *Adolescent Mothers*

The Health Department, as well as many funding institutions such as the State of California Department of Health Services, considers teen mothers to be those between

15 and 19 years of age. The Health Department's Youth Health Education Program provides targeted prevention programs for adolescents in this age group such as the Community Challenge Grant and Peer Advocates Teaching Healthier Solutions (PATHS). Five zip codes within Long Beach (90802, 90804, 90805, 90806, 90813) have teen birth statistics significantly higher than the State's rate (see map below). In Long Beach, in 1998 and 1999, the adolescent birth rates were 80.4 and 79.1 per 1,000 female population aged 15 to 19 years, respectively. The adolescent birth rates in California in 1998 and 1999 were 53.6 and 50.2 per 1,000 female population aged 15 to 19 years, respectively.

> In 1947, the crude birth rate was 32.9 per 1,000 population.

### *Birthweight and Prenatal Care*

Our best means of preventing infant mortality is to reduce the number of low birthweight

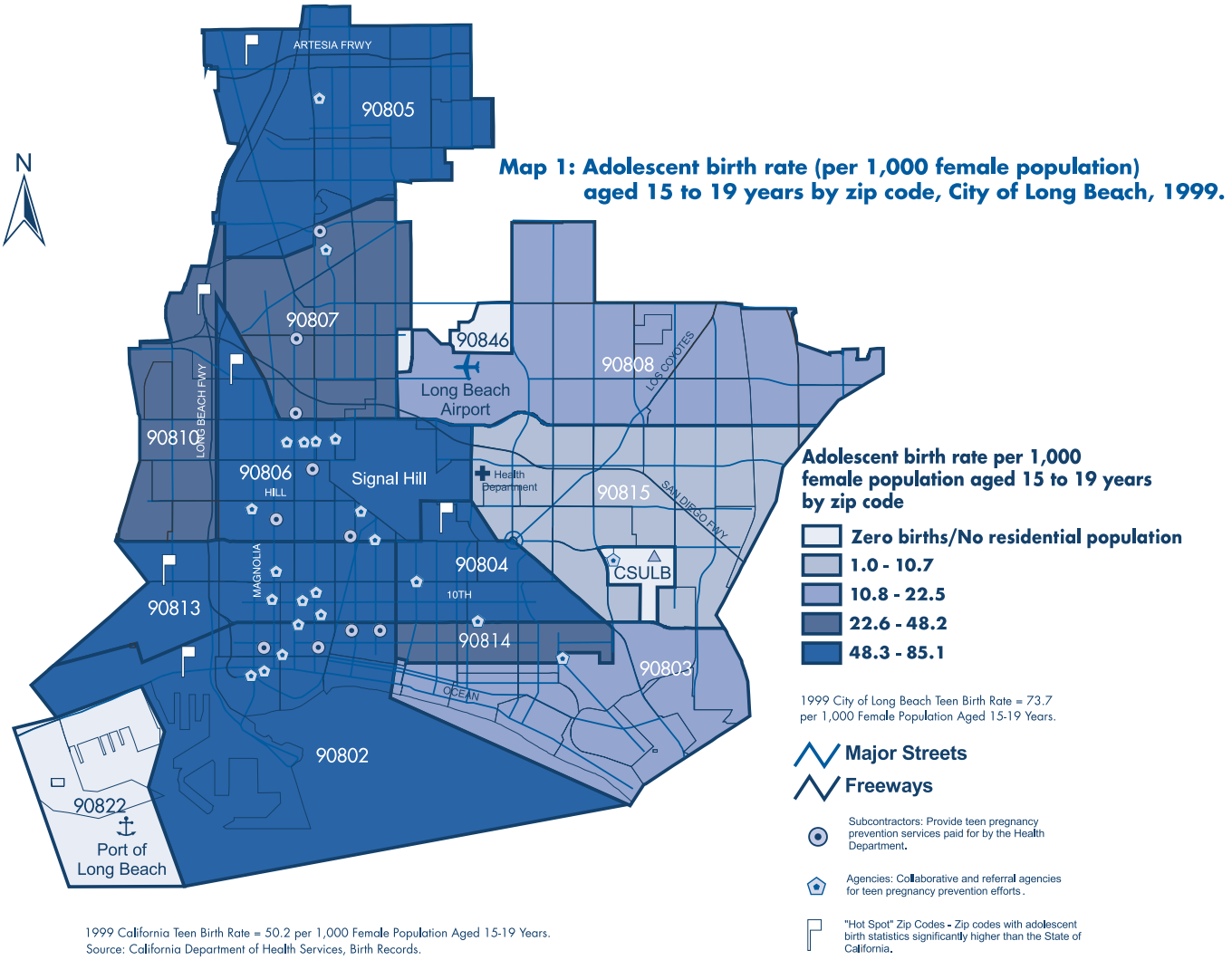
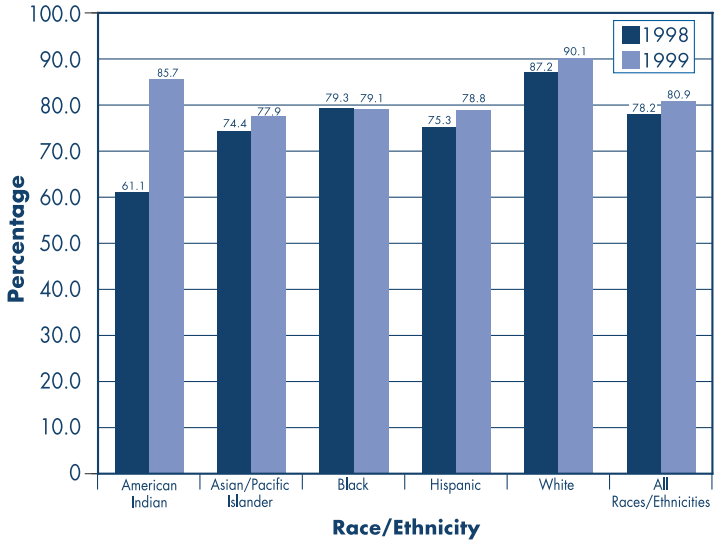


**Figure 4: Percentage of mother's receiving first trimester prenatal care by mother's race/ethnicity, City of Long Beach, 1998 and 1999.**




Total cases for 1998 = 6,657 (American Indian=11, Asian/PI=841, Black=1,098, Hispanic=3,172, White=1,520, Unspecified=15)
Total cases for 1999 = 6,874 (American Indian=12, Asian/PI=844, Black=2,065, Hispanic=3,446, White=1,497, Unspecified=10)
Source: California Department of Health Services, Vital Statistics.

babies and ensure that women receive adequate and early prenatal care. Insuring access to prenatal and well baby visits will help to reduce infant deaths.

Low birthweight is a factor associated with neonatal mortality. Low birthweight infants are more likely to experience long-term disabilities or to die during the first year of life than are infants of normal weight. Among all races/ethnicities in the City of Long Beach in 1998 and 1999, the incidence of low birthweight babies was 62.4 and 73.7 births per 1,000 live births, respectively. Blacks had the highest incidence rate of low birthweight babies with 99.6 and 129.9 births per 1,000 live births in 1998 and 1999, respectively.

In the City of Long Beach, 78.2% and 80.9% of mothers received prenatal care within the first trimester of pregnancy in 1998 and 1999, respectively. White mothers had the highest percentage of first trimester prenatal care in 1998 and 1999 with 87.2% and 90.1%, respectively. Asian/Pacific Islander mothers had the lowest percentage of prenatal care within the first trimester, with 74.4% and 77.9% in 1998 and 1999, respectively. A breakdown of low birthweight births and prenatal care percentages by mother's race/ethnicity are illustrated in the data appendix.

## Deaths

Ranking the causes of death is a popular method of presenting mortality statistics. Cause-of-death ranking is a useful tool for illustrating the relative burden of cause-specific mortality. The rankings denote the most frequently occurring causes of death among those causes eligible to be ranked, as classified by the International Classification of Diseases, Ninth and Tenth Revisions (ICD-9 and ICD-10).

### *Leading Causes of Death*

In the City of Long Beach, the leading causes of death in 1998 were (in rank order): coronary heart disease, malignant neoplasms (cancer), influenza/pneumonia, chronic lower respiratory disease, and cerebrovasular disease (stroke). In 1999, the leading causes of death in rank order were: coronary heart disease, cancer, stroke, chronic lower respiratory disease, and influenza/pneumonia. The 10 leading causes of death for both 1998 and 1999 accounted for 82% of deaths occurring to Long Beach residents (see Table 1).

Leading causes of death vary substantially by age. Cancer, AIDS and unintentional injuries were typically ranked among the leading causes of death for younger age groups for both 1998 and 1999. In adults 65 years and older, mortality due to chronic diseases such as coronary heart disease and chronic lower respiratory disease were most prevalent. Other prevalent chronic causes of death among older age groups were stroke and influenza/pneumonia.

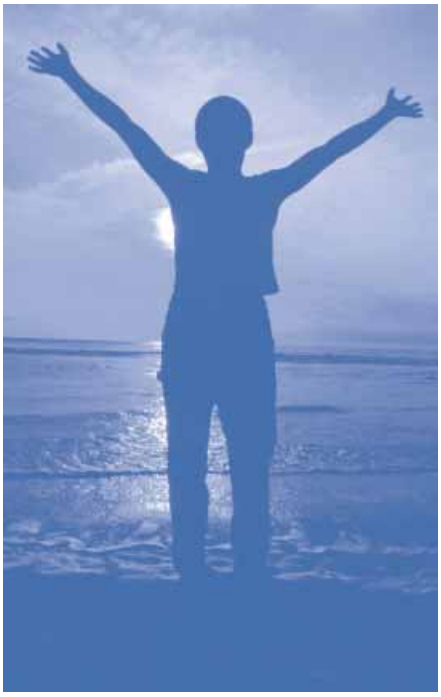
## Table 1: Ten leading causes of death by gender, City of Long Beach, 1999.

| CAUSE OF DEATH | NUMBER OF DEATHS | | | |
|---|---|---|---|---|
| | Male | Female | Total (%) | Rank in 1998 |
| 1.Coronary Heart Disease | 522 | 579 | 1,101 (33.6%) | 1 |
| 2.Cancer | 344 | 327 | 671 (20.5%) | 2 |
| 3.Cerebrovascular Disease (Stroke) | 96 | 149 | 245 (7.5%) | 5 |
| 4.Chronic Lower Respiratory Disease | 105 | 108 | 213 (6.5%) | 4 |
| 5.Influenza/Pneumonia | 53 | 71 | 124 (3.8%) | 3 |
| 6.Accidents | 70 | 30 | 100 (3.1%) | 6 |
| 7.Diabetes | 32 | 40 | 72 (2.2%) | 6 |
| 8.Liver Disease/Cirrhosis | 35 | 22 | 57 (1.7%) | 8 |
| 9.AIDS | 48 | 7 | 55 (1.7%) | 10 |
| 10.Assault (Homicide) | 39 | 10 | 49 (1.5%) | 7 |
| All Other Causes | 314 | 275 | 589 (18.0%) | |
| **Total Deaths** | **1,658** | **1,618** | **3,276** | |

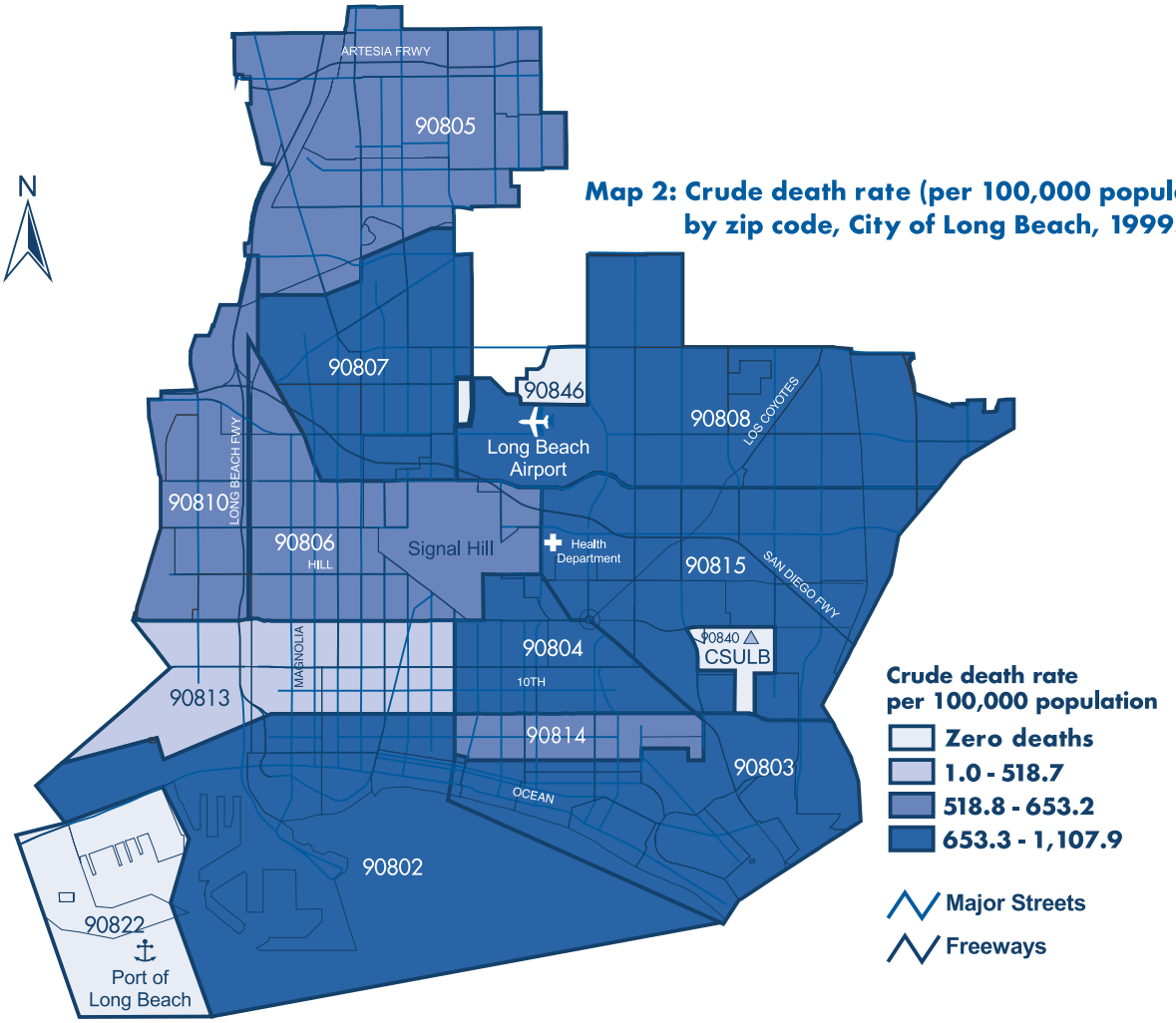
Source: California Department of Health Services, Vital Statistics.
Note: Suicide was the 9th leading cause of death in Long Beach in 1998.

The top five leading causes of deaths among males and females were nearly the same, with the exception of stroke, where 61% of the deaths attributed to stroke were among females in both 1998 and 1999. With AIDS, unintentional injuries and homicide, males exceeded females with number of deaths in those categories. Adults age 65 years and older comprised over 70% of the deaths among Long Beach residents in 1998 and 1999.

The four major racial/ethnic groups (e.g., Asian/Pacific Islander, Black, Hispanic, and White) share the top leading causes of death. The majority of deaths in 1998 and 1999 occurred among Whites, comprising 73% and 70% of the total deaths, respectively. Whites also comprised approximately three-fourths of the deaths due to coronary heart disease, cancer and stroke, and over 80% of the deaths due to influenza/pneumonia in both 1998 and 1999. This is due to the fact that Whites comprise 68% of the senior population 65 years and older and the majority of deaths occur among this age group.



In 1947, the crude death rate was 8.9 per 1,000 population. The top five leading causes of death were in rank order: disease of the circulatory system, cancer, accidents, diseases of the nervous system and organs of special senses, and diseases of the respiratory system.




**Map 2: Crude death rate (per 100,000 population) by zip code, City of Long Beach, 1999.**

Source: California Department of Health Services, Vital Statistics.
Note: In zip code 90822 there were a total of four deaths.
Total 1999 crude death rate in Long Beach = 762.9 per 100,000 population.

## Infant Mortality

Infant mortality is defined as the number of deaths occurring at less than one year of age per 1,000 live births. It is one of the best indicators of the overall health of a community. Great strides have been made in reducing the rate of infant mortality, which can be attributed to a lower rate of low birthweight babies - infants born weighing less than 5 pounds, 8 ounces or less than 2,500 grams. Other factors that influence the decline in the infant mortality are early prenatal care and improved medical technology to save very low birthweight babies. In addition to early prenatal care, preventive or well baby care is important in the first year of life to help prevent problems, which can cause death or disability. In the City of Long Beach, in 1998 and 1999, the infant mortality rates were 7.1 and 6.1 per 1,000 live births, respectively. The infant mortality rate in 1999 was significantly lower than in 1989 when the rate was 11.5 infant deaths per 1,000 live births. The infant death rate by race/ethnicity has also shown significant declines. The infant mortality rate for Blacks has declined steadily since 1989 when the infant mortality rate was 23.9 per 1,000 live births. In 1998 and 1999, the infant mortality rate among Blacks was 12.3 and 6.7, respectively. Since 1989, Blacks have had the highest infant mortality rates when compared to other races/ethnicities in Long Beach.

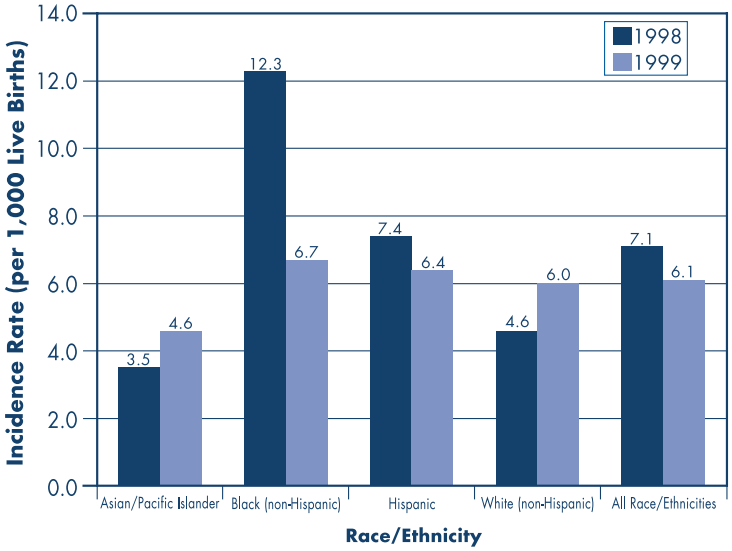
In 1942, the infant mortality rate was 37.0 per 1,000 live births.

In 1999, in the City of Long Beach the neonatal and post-neonatal mortality rates were 4.0 and 2.1 per 1,000 live births.

## Unintentional Injuries

Motor vehicle crashes, falls, poisonings, and fires are among the unintentional injuries that cause premature death. These deaths are most often the unintended result of preventable circumstances. Motor vehicle crashes accounted for 45% and 30% of the unintentional deaths in 1998 and 1999, respectively. Poisonings accounted for 23% and 35% unintentional deaths, in 1998 and 1999, respectively. In both 1998 and 1999, males accounted for nearly 70% of all deaths due to unintentional injuries.

**Figure 5: Incidence rate (per 1,000 live births) of infant mortality by race/ethnicity, City of Long Beach, 1998 and 1999.**




Total infant deaths 1998 = 60 (Asian/PI=4, Black=17, Hispanic=31, White=8)
Total infant deaths 1999 = 52 (Asian/PI=5, Black=9, Hispanic=28, White=10)
Note: No infant mortality was observed for the American Indian population.
Source: California Department of Health Services, Vital Statistics.

# COMMUNICABLE DISEASES

## Microbial Threats Facing the Public's Health

### *Food- and Water-Borne Diseases*

More than a century ago, typhoid fever and cholera were common foodborne diseases in the United States causing a high incidence of morbidity and mortality. However, enhancements of public health measures such as improvements in food safety, pasteurization of milk, and chlorination and disinfection of water supplies have led to decreased incidence of enteric disease outbreaks attributed to microbial or chemical contamination of food, milk and water. Food-and water-borne diseases continue to be public health threats as new strains of bacteria and the discovery of parasites and viruses that cause foodborne diseases emerge.

Today, more than 250 foodborne diseases have been identified, with varying symptoms

**Table 2: Selected reportable diseases by year, City of Long Beach, 1994-2000.**

| | YEAR | | | | | | |
|---|---|---|---|---|---|---|---|
| **DISEASE** | **1994** | **1995** | **1996** | **1997** | **1998** | **1999** | **2000** |
| AIDS* | 301 | 310 | 254 | 179 | 140 | 208 | 212 |
| Amebiasis | 13 | 13 | 16 | 13 | 13 | 7 | 6 |
| Campylobacteriosis | 60 | 56 | 93 | 92 | 67 | 74 | 70 |
| Chlamydial Infections | 1,697 | 1,270 | 1,351 | 1,454 | 1,592 | 1,898 | 2,044 |
| Giardiasis | 88 | 64 | 85 | 73 | 63 | 51 | 55 |
| Gonorrhea | 723 | 609 | 585 | 526 | 541 | 538 | 576 |
| H. Influenza | 5 | 3 | 5 | 7 | 0 | 0 | 0 |
| Hepatitis A | 123 | 206 | 195 | 168 | 72 | 78 | 60 |
| Hepatitis B (acute) | 32 | 21 | 20 | 8 | 15 | 13 | 18 |
| Hepatitis C (acute) | 0 | 0 | 0 | 0 | 1 | 0 | 1 |
| Measles | 5 | 3 | 0 | 1 | 0 | 1 | 1 |
| Meningitis (aseptic) | 17 | 22 | 35 | 30 | 87 | 49 | 38 |
| Meningococcal Infections | 1 | 3 | 5 | 7 | 2 | 4 | 2 |
| Non-Gonococcal Urethritis (NGU) | 99 | 309 | 301 | 245 | 182 | 141 | 123 |
| Pertussis | 3 | 2 | 7 | 2 | 5 | 16 | 9 |
| Rubella | 0 | 1 | 1 | 0 | 0 | 0 | 0 |
| Salmonellosis | 103 | 107 | 103 | 102 | 82 | 77 | 57 |
| Shigellosis | 79 | 97 | 82 | 89 | 65 | 58 | 54 |
| Syphilis** | 262 | 195 | 128 | 90 | 91 | 30 | 31 |
| Tuberculosis | 106 | 96 | 98 | 100 | 57 | 88 | 64 |

*AIDS data are reported cases. Data are provisional due to reporting delays.
**Syphilis data includes primary, secondary and early latent cases. Syphilis data are provisional due to reporting delays.

depending on their etiologic agent (e.g., bacteria, viruses, parasites, and natural and manmade chemicals). These diseases account for an estimated 76 million illnesses, 325,000 hospitalizations and 5,200 deaths in the United States each year (CDC).

Since the majority of foodborne diseases are sporadic occurrences and not part of larger recognized outbreaks, it is essential for health care providers to report known and suspected foodborne pathogens to the Health Department. Reporting these cases has significant implications to improving the public's health. By analyzing data on foodborne disease outbreaks, the Health Department can monitor trends over time in the incidence and prevalence of outbreaks caused by certain etiologic agents or by common errors in food handling. Moreover, the investigation and identification of pathogens causing foodborne disease outbreaks can lead to prevention and control measures at all levels of food production and handling. A summary of food-and waterborne diseases is illustrated in the data appendix for the years 1998 through 2000 by race/ethnicity and age group. The most commonly reportable diseases from 1994 through 2000 are listed in Table 2 with year-end totals.

## Campylobacter

Camplyobacteriosis is an infectious disease most commonly caused by the bacteria Camplyobacter jejuni and is the most common bacterial cause of diarrheal illness in the United States. In addition to diarrhea, symptoms of camplyobacteriosis include cramping, abdominal pain, and fever. In the City of Long Beach, in 1998 to 2000, campylobacter infections occurred mainly among Hispanics and were most prevalent among individuals aged birth to nine years. In the year 2000, the incidence rate in the City was 15.2 per 100,000 population.

## Giardiasis

Giardiasis is a commonly reported parasitic infection caused by Giardia intestinalis (also known as Giardia lamblia). This parasite is passed through fecal-oral contamination. Giardiasis is a recognized waterborne disease and can be passed through drinking untreated and freshwater. Giardia transmission is also associated with person-to-person transmission in day care centers, as well as swimming in contaminated recreational waters and bodies of freshwater. Anal intercourse can also facilitate transmission of giardia (Chin, 2000). In the City of Long Beach, in 1998 to 2000, giardia infections occurred mainly among Hispanics and were most prevalent among individuals aged birth to nine years and 30 to 39 years of age. In the year 2000, the giardia incidence rate in the City was 11.9 per 100,000 population.

## Hepatitis A

Hepatitis A is a liver disease caused by a viral infection, which is usually spread from person to person by fecal-oral contamination.

Good personal hygiene and proper sanitation can help prevent hepatitis A. Signs and symptoms of hepatitis A include jaundice, fatigue, fever, nausea, dark urine, and diarrhea. This vaccine preventable disease is the most common form of viral hepatitis. From 1997 to 1998 the incidence rate of hepatitis A decreased as much as 64%. In 1999 and 2000 the number of cases rose slightly from 1998, but remained lower than in 1997.

In 2000, the case rate for hepatitis A was 13.0 per 100,000 population. Children aged 14 and under accounted for 58% of all reported cases. In the same year, Hispanics accounted for 62% of all reported cases with a rate of 22.4 per 100,000 population.

## Salmonellosis

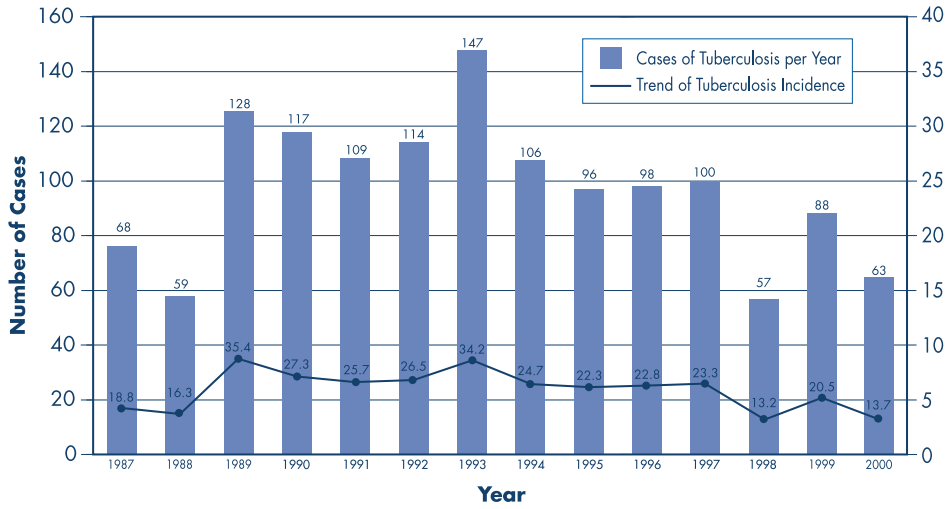
*Salmonella* is a group of bacteria that can cause diarrheal illness. *Salmonella* has been known to cause illness for over 100 years. This infection is usually transmitted to humans by eating contaminated food of animal origins such as beef, poultry, milk, or eggs. In some cases, raw vegetables may also become contaminated. *Salmonella* may also be transmitted by fecal-oral contamination spread by food handlers not performing proper hand washing. In the City of Long Beach, in the year 2000, the *Salmonella* incidence rate was 12.3 per 100,000 population. This represents a 102.4% decrease from 1995 when the rate was 24.9 per 100,000.

*Sources: Chin, J. (Ed.). (2000). Control of communicable diseases manual (17th ed.). Washington, D.C.: American Public Health Association. Center for Disease Control and Prevention.*

## Tuberculosis

Tuberculosis, or TB, is caused by *Mycobacterium tuberculosis*. The bacteria can attack any part of the body, but usually affects the lungs. TB was once the leading cause of death in the United States. In the 1940's, scientists discovered the first of several drugs now used to treat TB, and as a result, TB began to slowly disappear. However, in the late 1980's, cases began to increase and TB once again became a public health concern. TB is spread through the air from one person to another, usually by coughing or sneezing. Being foreign born is a common risk factor for TB in Long Beach due to the fact that many foreign-born residents have immigrated from countries where TB is endemic. In Long Beach, from 1998 to 2000, TB cases have remained steadily lower than in the early 1990's, when the incidence rate was as high as 34.2 per 100,000 population. The incidence rates in 1998, 1999 and 2000 were 13.3, 19.5 and 13.7 per 100,000 population, respectively.

**Figure 6: Tuberculosis cases by year with trend of tuberculosis incidence (per 100,000 population), City of Long Beach, 1987-2000.**




Source: Long Beach Department of Health and Human Services, Epidemiology Program.

In 1953, a full-time minifilm X-ray program was conducted by the Health Department. A total of 18,030 films were taken. The TB incidence rate was 60.2 per 100,000 population.

# PREVENTION, THE ULTIMATE PROTECTION

# PREVENTION, THE ULTIMATE PROTECTION

## Immunization

A cornerstone of public health is the delivery of childhood vaccinations. The City of Long Beach has very low rates of vaccine preventable diseases such as measles, mumps and rubella, which suggests that children receiving the full recommended series of vaccinations are well protected.

The California Department of Health Services recommends childhood immunizations against polio, hepatitis B, diphtheria, tetanus, pertussis, invasive haemophilus infections (associated with bacterial meningitis), measles, mumps, rubella, and chicken pox (see Table 3). The Health Department collects local immunization data from all public clinics. This data includes the estimated vaccination coverage with the 4:3:1:3:3 series (4 DtaP, 3 polio, 1 MMR, 3 Hib, 3 hep B) of children through the age of two years. In the year 2000, 68% of two year olds seen in public clinics in Long Beach received the basic recommended series. Additionally, that year, the average percentage for up-to-date immunizations from 46 private health care providers in Long Beach was 82%. Thus, the overall percentage of two-year-old children receiving the recommended vaccination for the year 2000 among both public clinics and the 46 private providers was 71%. This data does not capture children who were immunized in another jurisdiction or by other private health care providers. In 2000, the national estimated vaccination coverage with the 4:3:1:3:3 series was 73%, and in the State of California was 72%.

**Table 3: Recommended immunization timing.**

**Immunization Timing**

| Age | Vaccine | Series |
|---|---|---|
| 2 months | Polio | 1 of 3 |
| | Hep B | 1 of 3 |
| | DtaP | 1 of 4 |
| | Hib | 1 of 4 |
| 4 months | Polio | 2 of 3 |
| | Hep B | 2 of 3 |
| | DtaP | 2 of 4 |
| | Hib | 2 of 4 |
| 6 months | Hep B | 3 of 3 |
| | DtaP | 3 of 4 |
| | Hib | 3 of 4 |
| 12 months | Polio | 3 of 3 |
| | Varicella | 1 of 1 |
| | MMR | 1 of 1 |
| | Hib | 4 of 4 |
| 15 months | DtaP | 4 of 4 |

**Vaccine Key:**

| | |
|---|---|
| Polio | Polio |
| Hep B | Hepatitis B |
| DtaP | Diphtheria, Tetanus, and Pertussis |
| Hib | Invasive Haemophilus Infections - associated with bacterial meningitis |
| Varicella | Chicken pox |
| MMR | Measles, Mumps, Rubella |

Source: California Department of Health Services, Immunization Branch.

In 1947, the Health Department administered 12,885 smallpox vaccinations.

# BLOOD-BORNE AND SEXUALLY TRANSMITTED DISEASES

# BLOOD-BORNE AND SEXUALLY TRANSMITTED DISEASES

Sexually transmitted diseases (STDs) are among the most common infectious diseases in the United States. More than 20 STDs have been identified and affect more than 13 million men and women each year from all backgrounds and socioeconomic levels. STDs are most prevalent among young adults under 25 years of age. Nearly two-thirds of all STDs occur among young adults in Long Beach.

Behavioral risk factors for STDs include multiple partners, a partner with a STD diagnosis, young age at first intercourse and inconsistent and/or no use of barrier methods, primarily condoms.

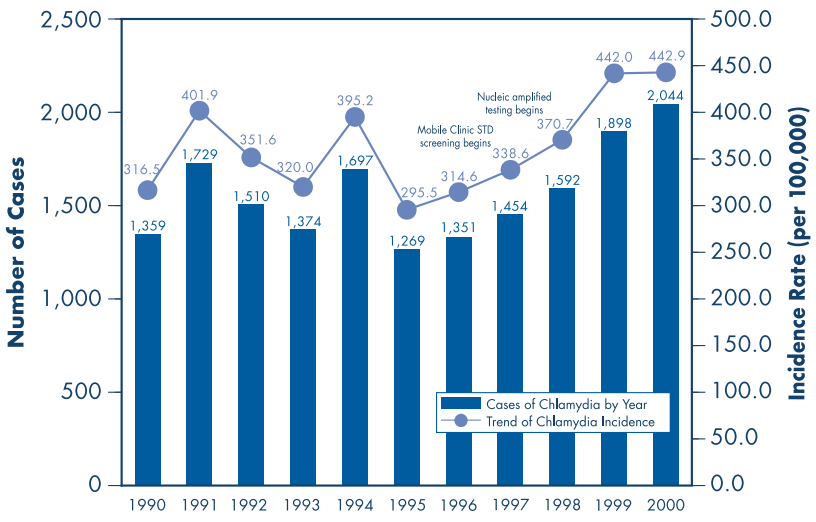
Many times, STDs are asymptomatic or symptoms are confused with diseases other than those transmitted through sexual contact. When diagnosed early, many STDs can be treated effectively. However, some bacterial infections have become resistant to the drugs used to treat them and now require newer types of antibiotics. Additionally, having an STD increases one's risk for becoming infected with HIV.

## Chlamydia

Chlamydia is the most common reportable disease in the United States and in Long Beach. Chlamydial infection is caused by the bacterium Chlamydia trachomatis and is transmitted through sexual contact with an infected partner. In both men and women, chlamydial infection may cause an abnormal genital discharge and burning with urination. In women, untreated infection may lead to pelvic inflammatory disease (PID), one of the most common causes of ectopic pregnancy and infertility in women. Chlamydia is easily treated with antibiotics.

In the City of Long Beach, the incidence of chlamydia has risen steadily from year to year. This increase may be due in part to sexually active individuals with multiple sex partners having unprotected sex, but more likely due to advances in diagnostic testing and patient-friendly procedures for testing, which have aided in the diagnosis of chlamydia cases. In 2000, the incidence rate was 442.9 per 100,000 population. Sixty-four percent of the cases occurred among adolescents and young adults aged 15 to 24 years of age. Of these cases 30% occurred among Hispanic females.

**Figure 7: Cases of chlamydia by year with trend of chlamydia incidence (per 100,000 population), City of Long Beach, 1990-2000.**




Source: Long Beach Department of Health and Human Services, Epidemiology Program.

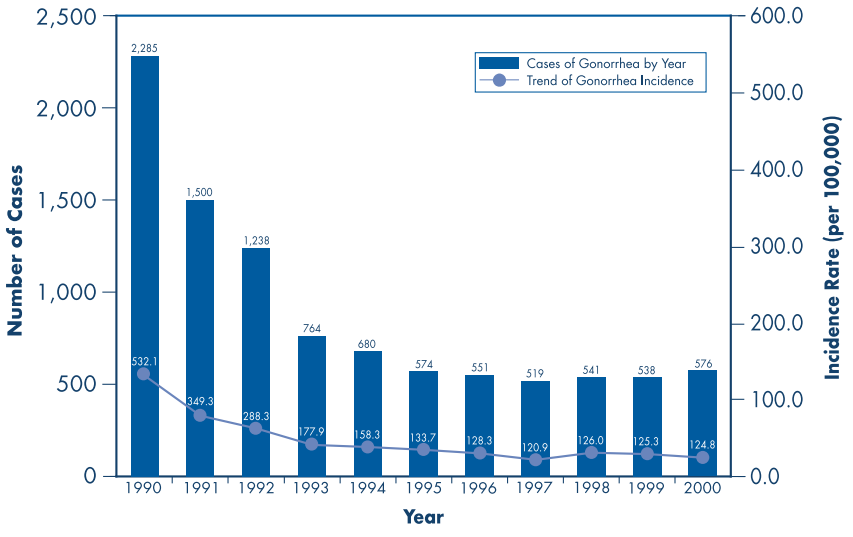
## Gonorrhea

Gonorrhea is caused by the bacterium, Neisseria gonorrhoeae. It is second only to chlamydial infections in the number of STD cases reported. Like chlamydia, it is transmitted through unprotected sexual intercourse. Antibiotics have been used to treat gonorrhea, but in the last decade, new antibiotic resistant strains of gonorrhea have emerged. Newer

antibiotics are used to treat these resistant strains. The incidence of gonorrhea is highest in high-density urban areas and among persons under 24 years of age who have multiple sex partners and engage in unprotected sexual intercourse.

From 1998 to 2000, in the City of Long Beach, gonorrhea cases rose slightly. In the year 2000, the case rate was 124.8 per 100,000 population. Forty-six percent of the cases occurred among individuals aged 15 to 24 years of age. Young adults aged 25 to 29 years also comprised a significant percentage of the total cases (19%). Blacks comprised 51% of the total gonorrhea cases in 2000. Black females aged 15 to 24 comprised 39% of all gonorrhea cases among Blacks and 20% of all cases in 2000.

**Figure 8: Cases of gonorrhea by year with trend of gonorrhea incidence (per 100,000 population), City of Long Beach, 1990-2000.**




Source: Long Beach Department of Health and Human Services, Epidemiology Program.

In 1936, the gonorrhea incidence rate was 377.8 per 100,000 population.

## Hepatitis B - Carrier

The hepatitis B virus can cause lifelong infection, cirrhosis (scarring) of the liver, liver cancer, liver failure, and death. The signs and symptoms of hepatitis B include jaundice, fatigue, nausea, vomiting, and joint pain. Hepatitis B is spread through blood and other bodily fluids. Transmission of hepatitis B may occur through unprotected sexual contact with an infected person, injection drug use and from an infected mother to her baby during childbirth. In 2000, acute hepatitis incidence was 3.9 per 100,000 population. However, in 2000 the incidence of reported hepatitis B carriers was 76.1 per 100,000 population, with the majority of carriers occurring among Asian/Pacific Islanders, with a rate of 266.9 per 100,000 population.

## Hepatitis C - Carrier

Hepatitis C is a viral infection affecting the liver. Signs and symptoms of hepatitis C are similar to that of hepatitis A and B. Transmission of hepatitis C occurs when blood or other bodily fluids from an infected person enters the body of another person. The Centers for Disease Control and Prevention (CDC) estimates that injection drug use accounts for 60% of all new cases of hepatitis C. Sexual transmission accounts for 15% of the cases.

In the City of Long Beach, in the year 2000, only one acute case of hepatitis C was reported, however 860 hepatitis C carriers were reported with a rate of 186.3 per 100,000 population. When race/ethnicity was specified, Whites comprised the majority of the carriers from 1998 to 2000. However, Blacks had the highest incidence rate among all races in the same time period (see data appendices).

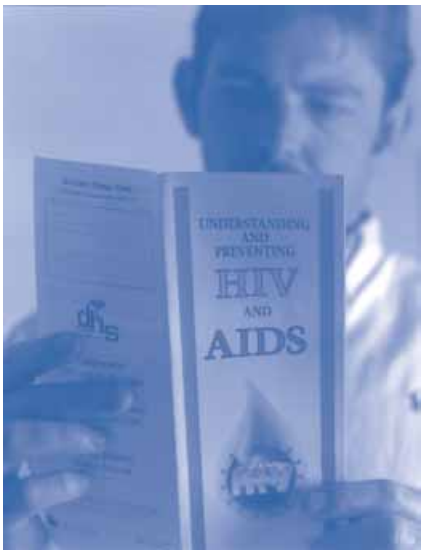
# RESPONDING TO EMERGING EPIDEMICS

## Twenty Years of HIV/AIDS

On June 5, 1981, the Centers for Disease Control and Prevention issued its first warning about a relatively rare form of pneumonia among a group of homosexual men in Los Angeles, which was later determined to be Acquired Immune Deficiency Syndrome (AIDS)-related. Since 1981, more than 750,000 cases of AIDS have been reported in the United States and almost half a million Americans have died of the disease. It is estimated that more than 36 million individuals are living with HIV/AIDS worldwide.

June 5, 2001 marked the 20th anniversary of the AIDS epidemic. HIV/AIDS has developed into a global public health issue with no vaccine or cure and HIV cases continue to increase rapidly. The AIDS epidemic in the United States was identified when five white gay men in Los Angeles, California were diagnosed with Pneumocystis carinii pneumonia (PCP). Since then, the AIDS epidemic has grown to affect males and females of all age groups and racial/ethnic backgrounds, with risk factors for infection including: men who have sex with men (MSM); injection drug use (IDU); heterosexual contact; and MSM/IDU.

AIDS has left an indelible mark on the United States. Its impact goes beyond the disease itself. AIDS activism has affected the Food and Drug Administration's (FDA) expedited drug approval process, health care delivery and the public health response to this emerging communicable disease, by controlling the outbreak and promoting awareness and prevention.




During this twenty-year period, there has been a great deal of progress in the fight against AIDS. Wide-spread use of antiretroviral drugs has contributed to fewer new AIDS cases and AIDS-related deaths. More people are living with HIV/AIDS than ever before and are in need of services; however, high cost of care presents a significant barrier for people with HIV/AIDS. In addition to this, significant disparities in care and services exist across age groups and race/ethnicities.

Although progress is steady, an effective vaccine is still years away from being developed. Therefore, proven prevention programs should still be used to educate people about HIV/AIDS transmission and risk reduction.

*Source: Centers for Disease Control and Prevention. MMWR, 2001 Jun 1; 50(21); 430-434.*

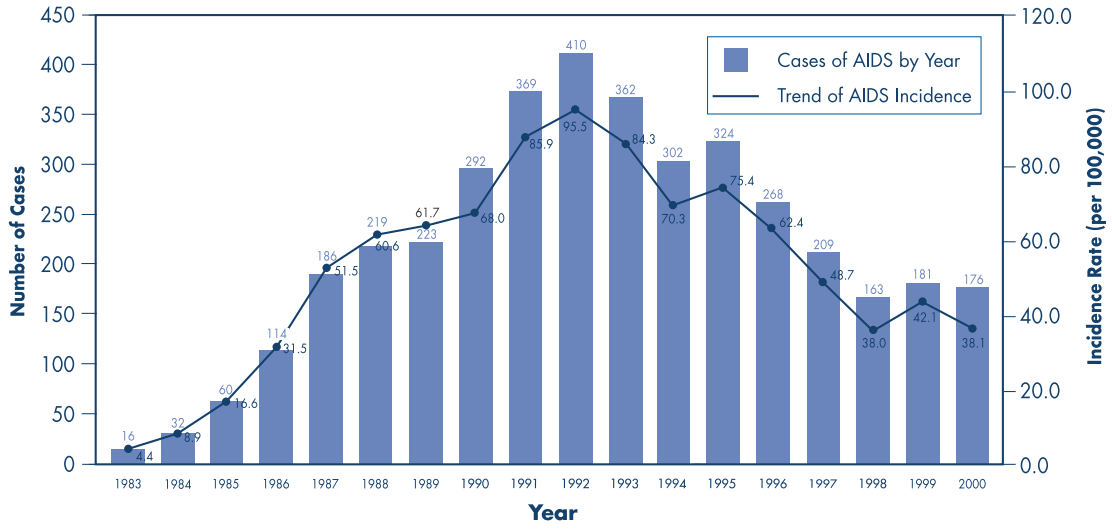
In the City of Long Beach, there were 3,917 cumulative reported AIDS cases through December 31, 2000. Since the first reported case in the City in the early 1980's, AIDS has affected a broad spectrum of individuals and age groups.

By risk, male-to-male sexual contact, injection drug use, and MSM/IDU are the most prevalent modes of transmission among adult/adolescent

reported AIDS cases in the City of Long Beach. MSMs had the highest percentage of exposure, comprising 76% of all reported AIDS cases through 2000. IDUs and MSM/IDUs each comprised 8% of the cumulative reported cases in the City. By gender, 94% of the cumulative reported AIDS cases in Long Beach were among males. Women are also significantly infected primarily through heterosexual contact and IDU.

By race/ethnicity, 63% of the cumulative reported AIDS cases through 2000 were among Whites. However, demographic shifts in AIDS cases have occurred with respect to race/ethnicity. When looking at the number of cases diagnosed in a given year, AIDS surveillance data indicates changes in the persons diagnosed with AIDS. For instance, in 1998 and 1999, Blacks and Hispanics comprised 57% of the diagnosed AIDS cases. In 1999 and 2000, the percentage of diagnosed cases among minorities dropped to 49% and 47%, respectively. Additional information on AIDS in the City of Long Beach and the nation is in the data appendices.


**Figure 9: Diagnosed AIDS cases by year, with trend of AIDS incidence (Per 100,000 population), City of Long Beach, 1983-2000.**




Source: Long Beach Department of Health and Human Services, HIV/AIDS Epidemiology Program.

From 1998 to 2000, the Health Department administered an average of 4,667 HIV tests per year.

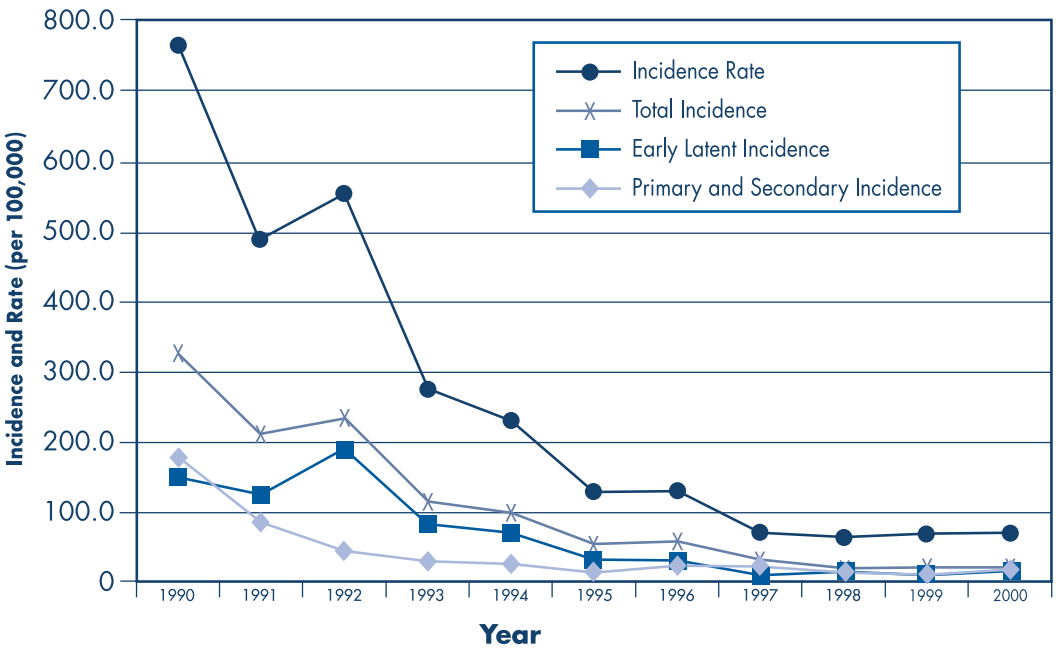
# ON THE PATH OF ELIMINATING PUBLIC HEALTH THREATS

## Syphilis

The time is now to move the nation toward eliminating one of the public health threats that has long been battled: syphilis. Syphilis is a complex, yet easily treated STD caused by a spiral-shaped bacteria called a spirochete. Infection with the syphilis bacterium, Treponema pallidum, once a cause of devastating epidemics, can easily be prevented.

Given adequate access to and utilization of health care, syphilis is easy to detect and cure. Nationally, syphilis is at the lowest rate ever recorded. In light of the national plan to eliminate syphilis from the United States, the City of Long Beach also has a unique opportunity to eliminate endemic syphilis while cases are still declining relative to statistics in the early 1990s. In Long Beach, in 1990, the total syphilis case rate was 105.7 per 100,000 population, and by 1999 the case rate had declined to 6.9 per 100,000 population. These declines can be attributed to several factors including, extensive confidential disease investigation, screening, diagnosis, treatment, and education targeted toward individuals at high-risk for syphilis.

**Figure 10: Trend of syphilis, incidence and rate (per 100,000 population), City of Long Beach, 1990-2000.**




Source: California Department of Health Services, STD Control.

In the year 2000, however, Long Beach syphilis surveillance statistics from January 1 through May 31 indicated an increase in cases reported among City residents. In Long Beach and Los Angeles County, a significant increase of early syphilis morbidity was detected in late February 2000 among gay and bisexual males;

many of whom are HIV co-infected. Subsequently, the Health Department launched an effective targeted investigation into the initial syphilis cases reported in February to identify additional cases linked to this outbreak. By mid-2000 the primary and secondary syphilis cases leveled off and by the end of the 2000, the total syphilis case rate was 6.7 per 100,000 population, which is comparable to the previous year's rates.

Epidemiological investigations associate the syphilis outbreak in early 2000 with individuals engaging in high-risk behavior, mainly men who have sex with men, many of whom also have chemical dependencies. Injected methamphetamines and alcohol abuse were especially noted among many of these men. Persons diagnosed with syphilis in Long Beach, reported having met sexual partners in bathhouses in Los Angeles County and in bars in both Long Beach and Los Angeles County, as well as via the Internet and telephone chat lines.

The combination of anonymous sex partners in bathhouses and individuals with chemical dependencies, heightened the spread of the syphilis epidemic, and has made identifying sexual partners and social networks to link infected individuals into clusters a difficult process. The response to the outbreak has been a strong, effective collaborative effort between neighboring health jurisdictions (e.g., Long Beach, Los Angeles and Orange Counties), the State of California STD Control Branch, the Centers for Disease Control and Prevention, and community-based organizations.

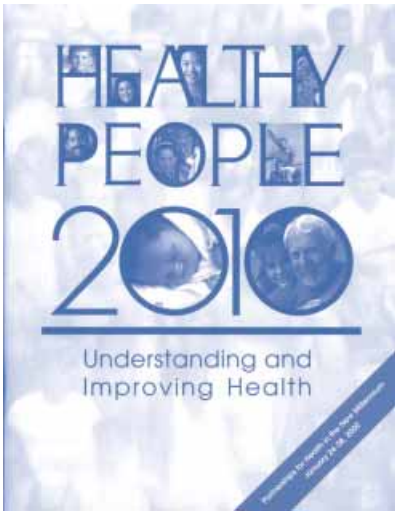
In 1942, the syphilis incidence rate was 310.0 per 100,000 population.

# WE ARE A HEALTHY COMMUNITY

# WE ARE A HEALTHY COMMUNITY

## Healthy People 2010

*Healthy People 2010* is a set of health objectives for the Nation to achieve over the first decade of the new century. It builds on initiatives pursued over the past two decades: the 1979 Surgeon General's Report, *Healthy People* and *Healthy People 2000*: National Health Promotion and Disease Prevention Objectives. *Healthy People 2010* is designed to measure the nation's health status over time and can be used to develop programs to improve health.




The Health Department has integrated *Healthy People 2010* into current and future programs and publications. By selecting from among the national objectives, an agenda for community health improvement in Long Beach will be built into programs and monitored over the course of this next decade.

*Healthy People 2010* is one way we measure our health status in the City of Long Beach. *Healthy People 2010* sets national health objectives for communities to measure their progress against the Nation's. The initiative is designed to identify the most significant preventable threats to health and to establish national goals to reduce these threats. Long Beach has reached the *Healthy People 2000* national goals for many health indicators, and is making progress in achieving the health goals for others in *Healthy People 2010*.

The *Healthy People 2010* contains broad reaching national health goals for the new decade.

### *Healthy People 2010* is designed to achieve two overarching goals:

1. Increase the quality and years of healthy life.
2. Eliminate racial and ethnic disparities in health status.

The Nation's progress in achieving these two overarching goals over the course of the decade will be monitored through 467 objectives grouped into 28 "focus areas."

### *Healthy People 2010* Focus Areas:

1. Access to quality health services
2. Arthritis, osteoporosis, and chronic back pain conditions
3. Cancer
4. Chronic kidney disease
5. Diabetes
6. Disability and secondary conditions
7. Educational and community-based programs
8. Environmental health
9. Family planning
10. Food safety
11. Health communication
12. Heart disease and stroke
13. HIV
14. Immunization and infectious diseases
15. Injury and violence prevention
16. Maternal, infant and child health
17. Medical product safety
18. Mental health and mental disorders
19. Nutrition and overweight
20. Occupational safety and health
21. Oral health
22. Physical activity and fitness
23. Public health infrastructure
24. Respiratory diseases
25. Sexually transmitted diseases
26. Substance abuse
27. Tobacco use
28. Vision and hearing

The objectives and focus areas are devoted to a comprehensive array of diseases, conditions, and public health challenges. Each objective has a target for specific improvements to be achieved by 2010. Many *Healthy People 2010* objectives target interventions designed to reduce or eliminate illness, disability, and premature death among individuals and communities. Other *Healthy People 2010* objectives strengthen public health services and improve the availability and dissemination of health related information.

The first-ever leading health indicators, comprising 10 areas of health status, based upon *Healthy People 2010* objectives were also released. These new measures will allow individuals to easily assess the overall health of the Nation, as well as that of their own communities, and make comparisons and improvements over time.

**The 10 leading health indicators:**

1. Physical activity
2. Overweight and obesity
3. Tobacco use
4. Substance abuse
5. Mental Health
6. Injury and violence
7. Environmental quality
8. Immunization
9. Responsible sexual behavior
10. Access to health care

The leading health indicators are supported by 21 specific measurable objectives that reflect the influence of behavioral and environmental factors and community health interventions.

*Healthy People 2010* bridges the relationship between individual and community health and community health and the Nation's health. The premise of *Healthy People 2010* is that the health of the individual is inseparable from the health of the community and by the same token, the health of every community determines the overall health status of the Nation.

More information on *Healthy People 2010* objectives, focus areas, and leading health indicators can be found on the Healthy People website at http://www.healthypeople.gov.

## HEALTHY PEOPLE IN ITS THIRD DECADE

**1979** • *Healthy People*: *The Surgeon General's Report on Health Promotion and Disease Prevention*

**1980** • *Promoting Health/ Preventing Disease: Objectives for the Nation*

**1990** • *Healthy People 2000*: *National Health Promotion and Disease Prevention Objectives*

*Source: U.S. Department of Health and Human Services, Healthy People 2010. Washington, D.C.: U.S. Department of Health and Human Services, Government Printing Office. 2000.*

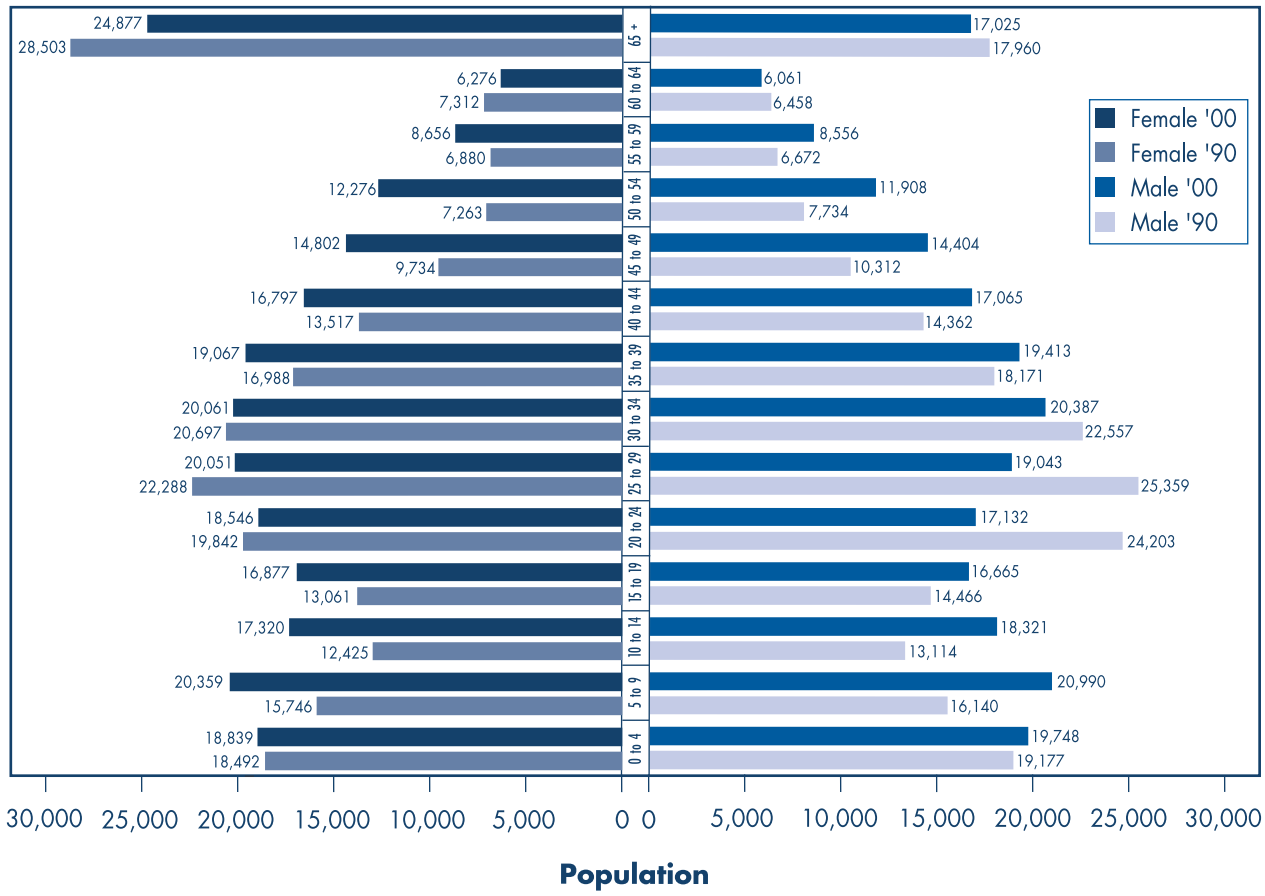
# APPENDICES

# DATA

# DEMOGRAPHICS

The Data Appendices of this report is a compilation of descriptive population data, vital records and commonly reported communicable disease statistics. The charts, graphs and maps that follow highlight data by age, gender, race/ethnicity, and geographic location, where available. The data records are presented in a summary format without further analysis. These data are considered official and are obtained from the U.S. Census Bureau, California Department of Health Services, Vital Statistics and the City of Long Beach Department of Health and Human Services, Epidemiology Program and the HIV/AIDS Epidemiology Program. Questions pertaining to the data may be directed to (562) 570-4382.

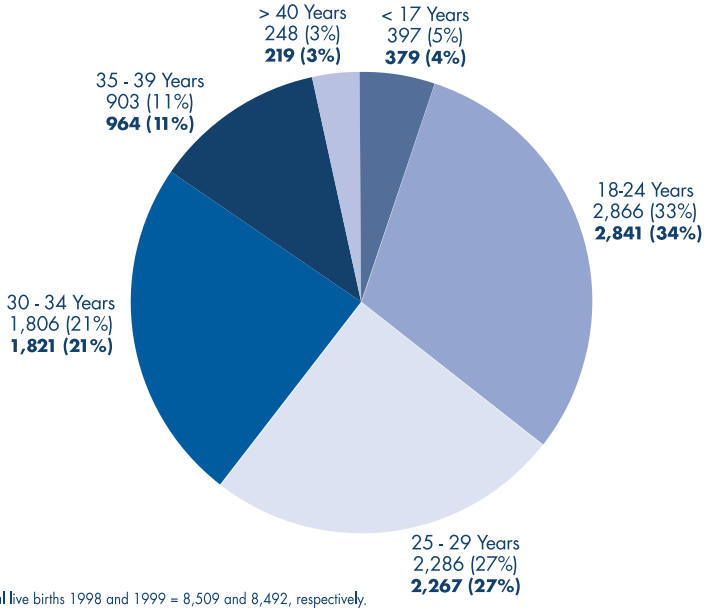
**Figure 11: Age distribution by gender, City of Long Beach, 1990 and 2000.**




Total population 1990 = 429,433 (Male = 216,685; Female = 212,748)
Total population 2000 = 461,522 (Male = 226,718; Female = 234,804)
Source: U.S. Census Bureau.

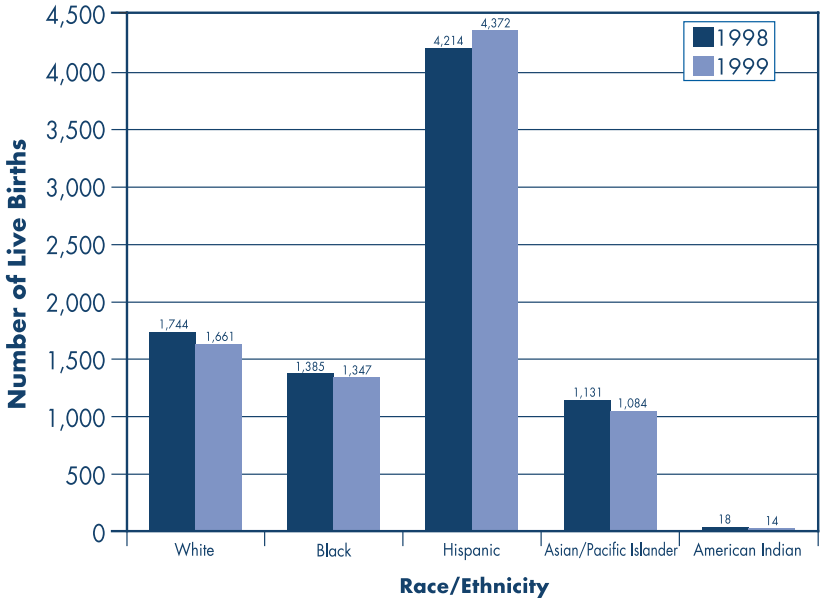
# BIRTHS AND DEATHS

**Figure 12: Live births by mother's age group, City of Long Beach, 1998 and 1999.***




Total live births 1998 and 1999 = 8,509 and 8,492, respectively.
* **Bold indicates 1999 births.**
**Mother's age group were unknown for 3 births in 1998 and 1 birth in 1999.
NOTE: Total percent may not equal 100 due to rounding.
Source: California Department of Health Services, Vital Statistics.

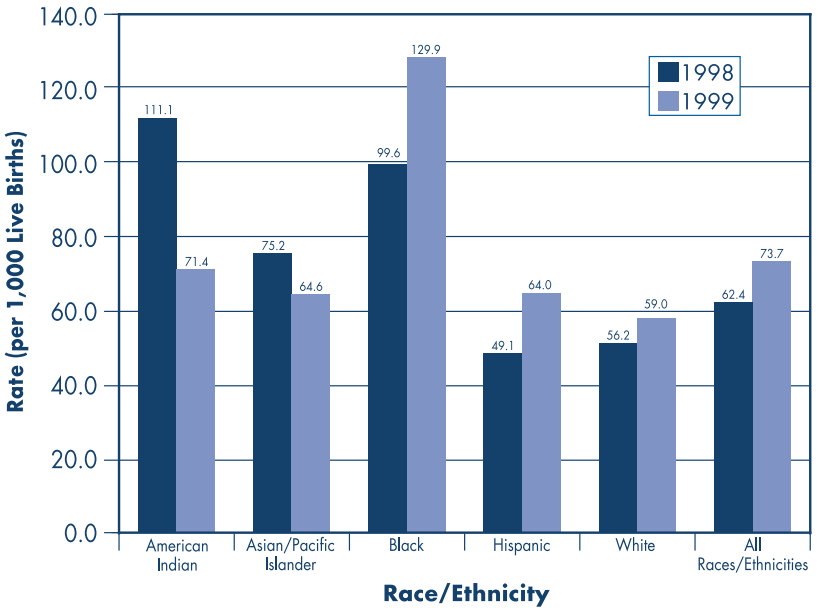
**Figure 13: Number of live births by mother's race/ethnicity, City of Long Beach, 1998 and 1999.**




Total live births for 1998 = 8,509
Total live births for 1999 = 8,492
Race/ethnicity were not specified for 17 births in 1998 and 14 births in 1999.
Source: California Department of Health Services, Vital Statistics.

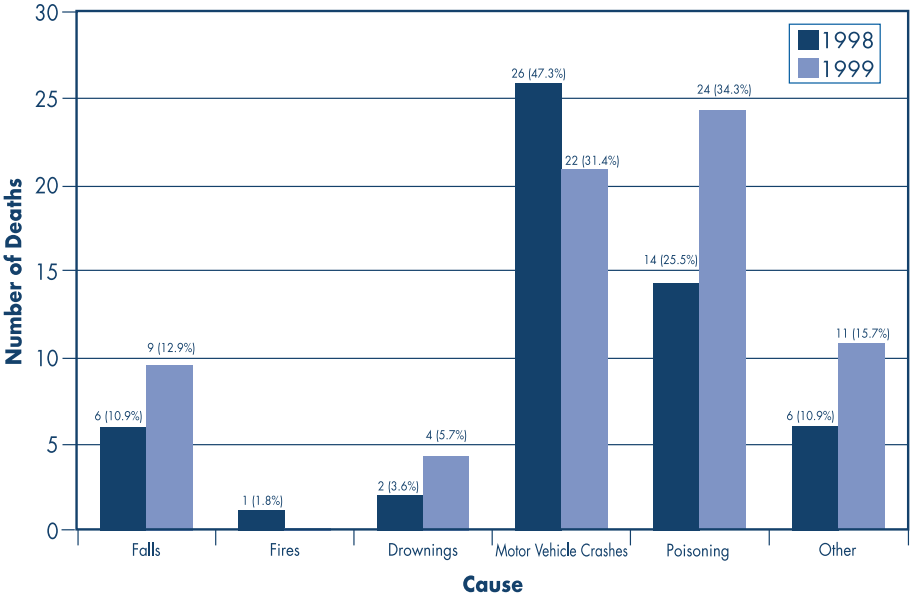
# BIRTHS AND DEATHS

**Figure 14: Incidence of low birthweight (per 1,000 live births) by mother's race/ethnicity, City of Long Beach, 1998 and 1999.**



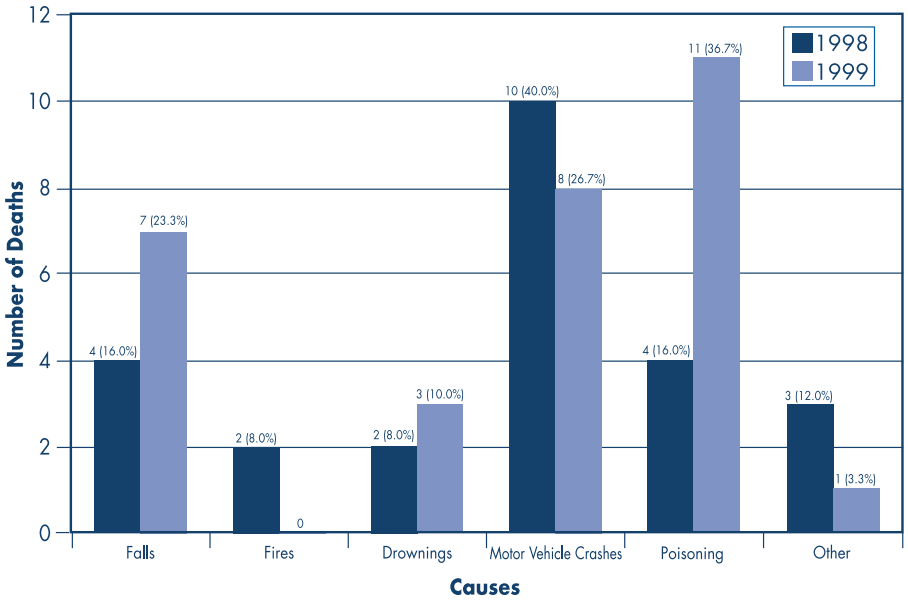

Total number of low birthweight births for 1998 = 531 (American Indian=2, Asian/PI=85, Black=138, Hispanic=207, White=98, Unspecified=1)
Total number of low birthweight births for 1999 = 626 (American Indian=1, Asian/PI=70, Black=175, Hispanic=280, White=98, Unspecified=2)
*Low birthweight = babies weighing <2,500g at birth.
Source: California Department of Health Services, Vital Statistics.

**Figure 15: Unintentional injury deaths in males by cause, City of Long Beach, 1998 and 1999.**



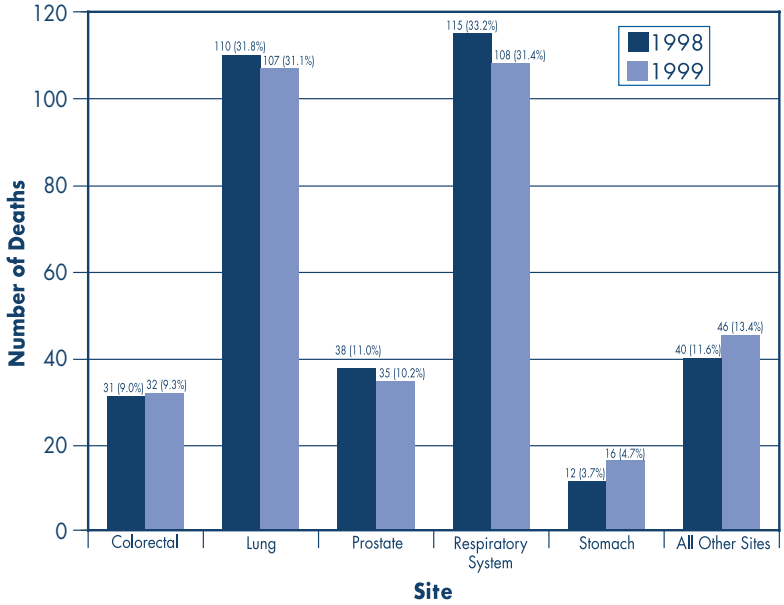

Total deaths for 1998 = 55
Total deaths for 1999 = 70
Source: California Department of Health Services, Vital Statistics.

**Figure 16: Unintentional injury deaths in females by cause, City of Long Beach, 1998 and 1999.**



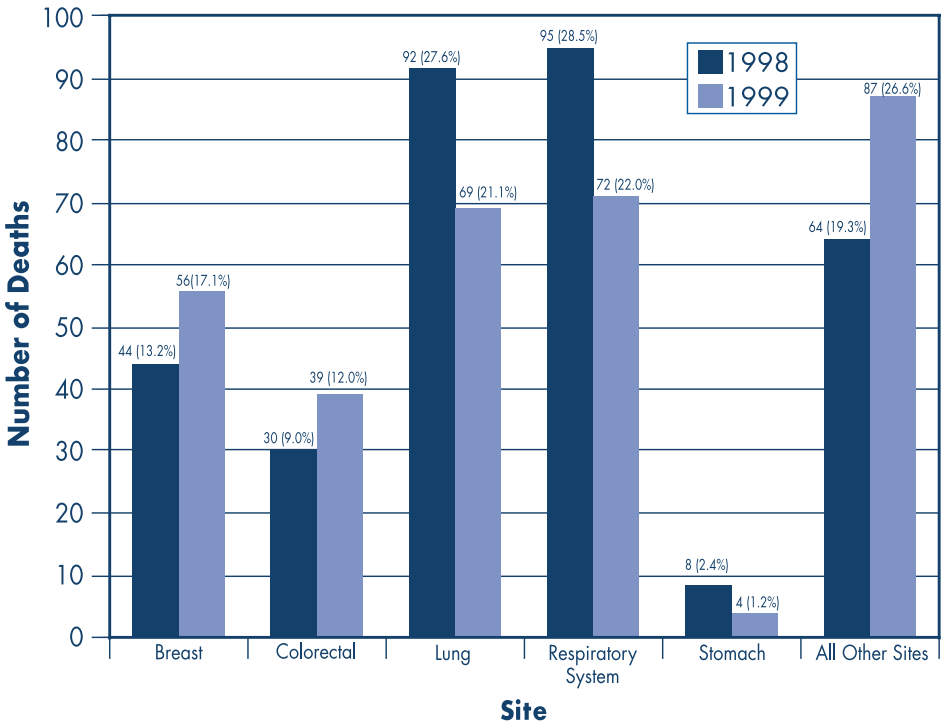

Total deaths for 1998 = 25
Total deaths for 1999 = 30
Source: California Department of Health Services, Vital Statistics.

**Figure 17: Cancer deaths in males by site, City of Long Beach, 1998 and 1999.**




Total Cases: 1998=346, 1999=344
Note: In 1999, lung cancer deaths included those attributed to cancer of the trachea and bronchis.
Source: California Department of Health Services, Vital Statistics.

**Figure 18: Cancer deaths in females by site, City of Long Beach, 1998 and 1999.**

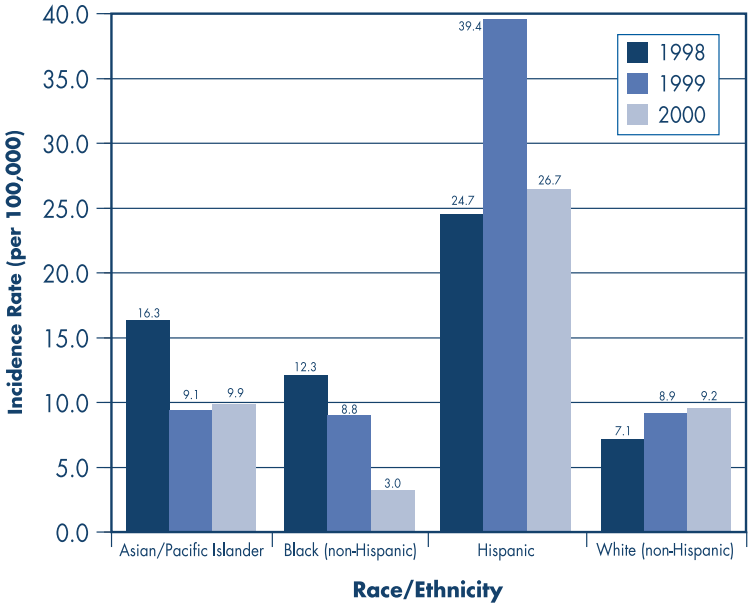



Total Cases:1998 = 333, 1999=327
Note: In 1999, lung cancer deaths included those attributed to cancer of the trachea and bronchis.
Source: California Department of Health Services, Vital Statistics.

"Long Beach: A New Dawn, A New Day" by artist Richard Wyatt and artist assistant Alberto Garibay. A Leadership Long Beach Class of 2000 project.

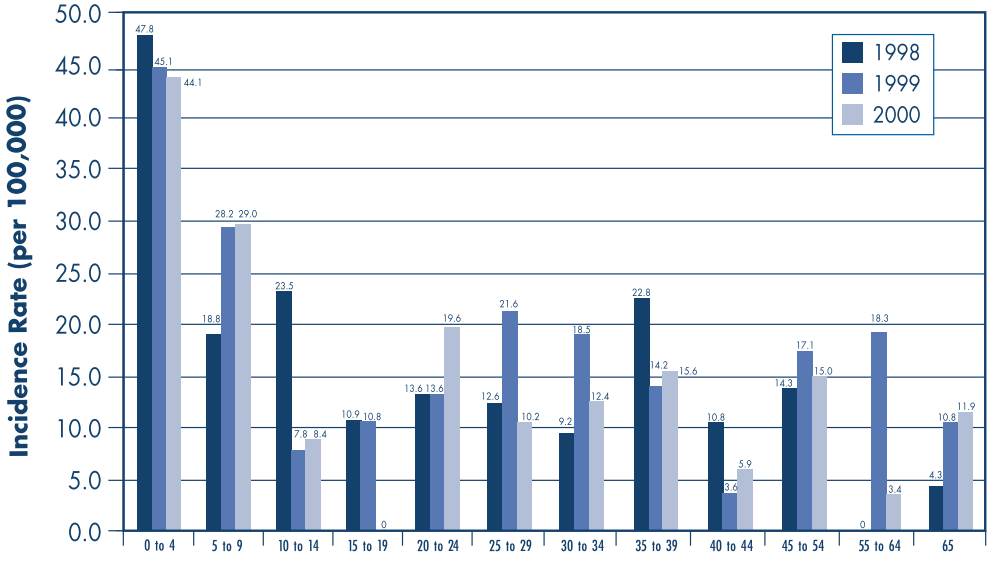
# FOOD- AND WATER-BORNE DISEASE

**Figure 19: Incidence rate (per 100,000 population) of campylobacteriosis by race/ethnicity, City of Long Beach, 1998-2000.**



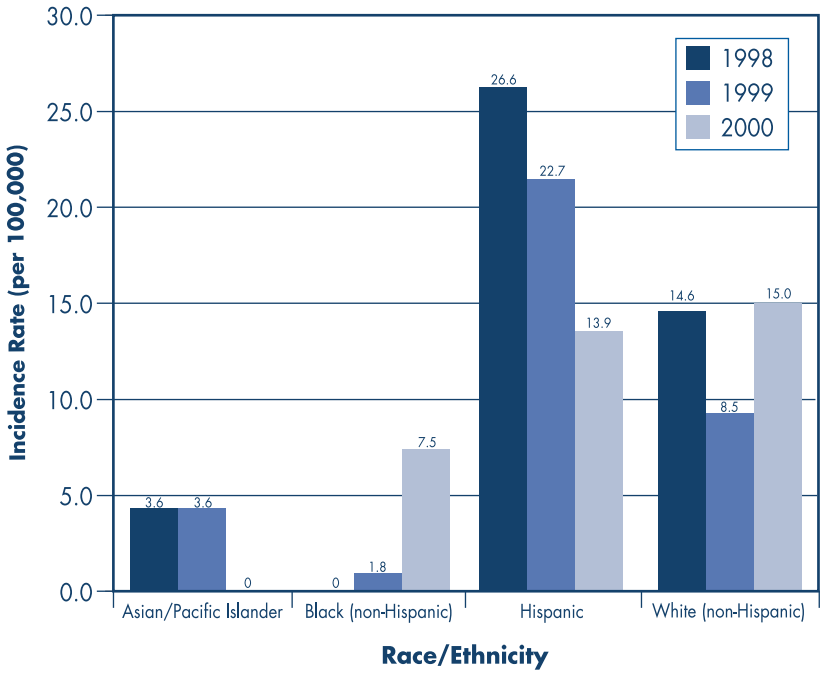

Total cases for 1998 = 67 (Asian/PI=9, Black=7, Hispanic=25, White=15, Unspecified=9)
Total cases for 1999 = 74 (Asian/PI=5, Black=5, Hispanic=40, White=19, Unspecified=4)
Total cases for 2000 = 70 (Asian/PI=6, Black=2, Hispanic=44, White=14, Unspecified=4)
Source: Long Beach Department of Health and Human Services, Epidemiology Program.

**Figure 20: Incidence rate (per 100,000 population) of campylobacteriosis by age group, City of Long Beach, 1998-2000.**



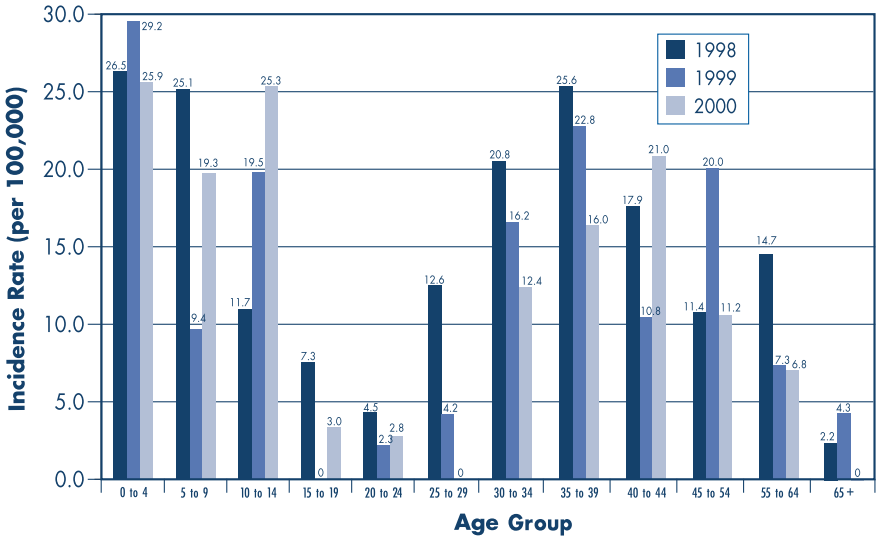

Total cases for 1998 = 67 (Asian/PI=9, Black=7, Hispanic=25, White=15, Unspecified=9)
Total cases for 1999 = 74 (Asian/PI=5, Black=5, Hispanic=40, White=19, Unspecified=4)
Total cases for 1998 = 67 (Asian/PI=6, Black=2, Hispanic=44, White=14, Unspecified=4)
Source: Long Beach Department of Health and Human Services, Epidemiology Program.

**Figure 21: Incidence rate (per 100,000 population) of giardiasis by race/ethnicity, City of Long Beach, 1998-2000.**




Total cases for 1998 = 63 (Asian/PI=2, Black=0, Hispanic=27, White=31, Unspecified=3)
Total cases for 1999 = 51 (Asian/PI=2, Black=1, Hispanic=23, White=18, Unspecified=7)
Total cases for 2000 = 55 (Asian/PI=0, Black=5, Hispanic=23, White=23, Unspecified=4)
Source: Long Beach Department of Health and Human Services, Epidemiology Program.

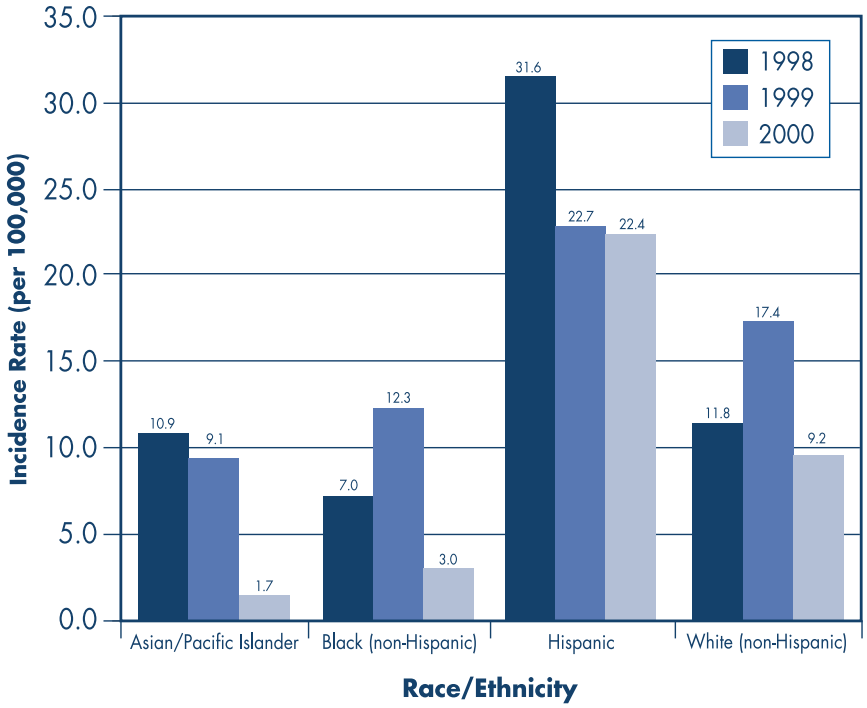
**Figure 22: Incidence rate (per 100,000 population) of giardiasis by age group, City of Long Beach, 1998-2000.**




Total cases for 1998 = 63 (Asian/PI=2, Black=0, Hispanic=27, White=31, Unspecified=3)
Total cases for 1999 = 51 (Asian/PI=2, Black=1, Hispanic=23, White=18, Unspecified=7)
Total cases for 2000 = 55 (Asian/PI=0, Black=5, Hispanic=23, White=23, Unspecified=4)
Source: Long Beach Department of Health and Human Services, Epidemiology Program.

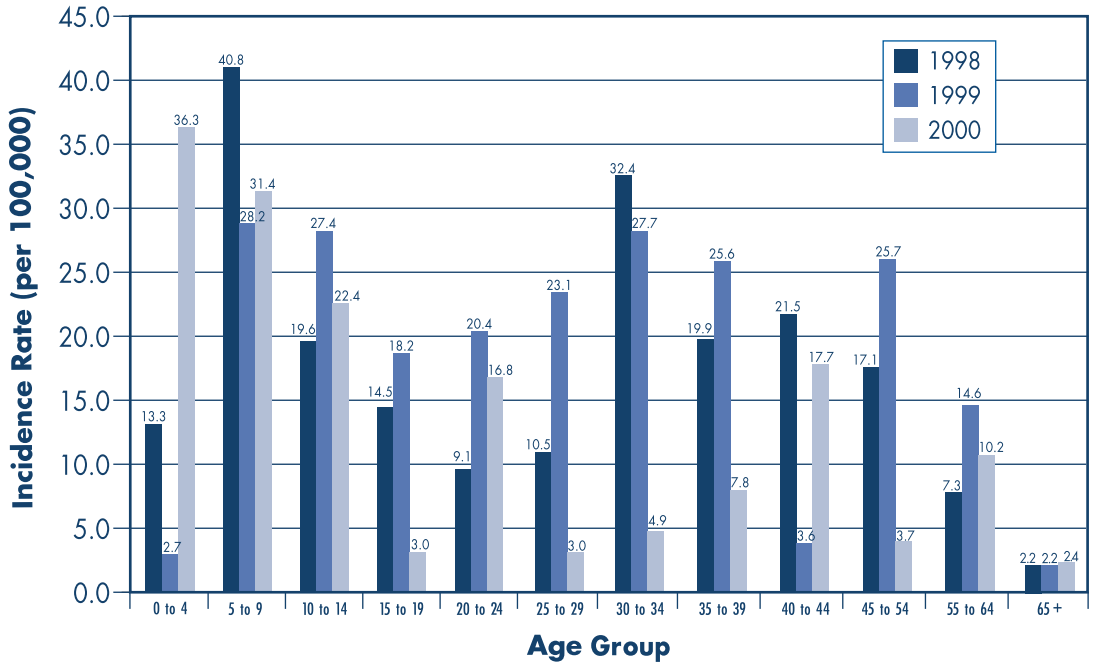
# FOOD- AND WATER-BORNE DISEASE

**Figure 23: Incidence rate (per 100,000 population) of hepatitis A by race/ethnicity, City of Long Beach, 1998-2000.**




Total cases for 1998 = 72 (Asian/PI=6, Black=4, Hispanic=32, White=25, Unspecified=5)
Total cases for 1999 = 78 (Asian/PI=5, Black=7, Hispanic=23, White=37, Unspecified=6)
Total cases for 2000 = 60 (Asian/PI=1, Black=2, Hispanic=37, White=14, Unspecified=4)
Source: Long Beach Department of Health and Human Services, Epidemiology Program.

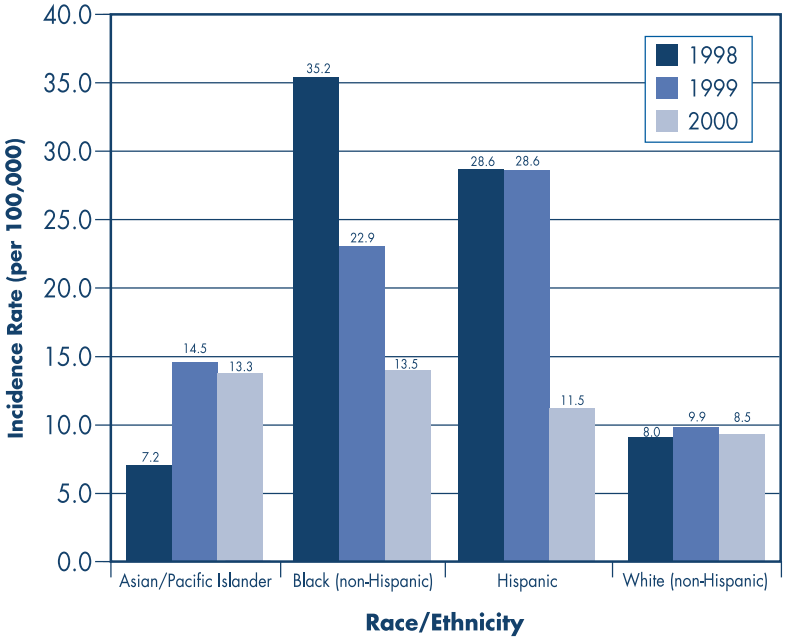
**Figure 24: Incidence rate (per 100,000 population) of hepatitis A by age group, City of Long Beach, 1998-2000.**




Total cases for 1998 = 72 (Asian/PI=6, Black=4, Hispanic=32, White=25, Unspecified=5)
Total cases for 1999 = 78 (Asian/PI=5, Black=7, Hispanic=23, White=37, Unspecified=6)
Total cases for 2000 = 60 (Asian/PI=1, Black=2, Hispanic=37, White=14, Unspecified=4)
Source: Long Beach Department of Health and Human Services, Epidemiology Program.

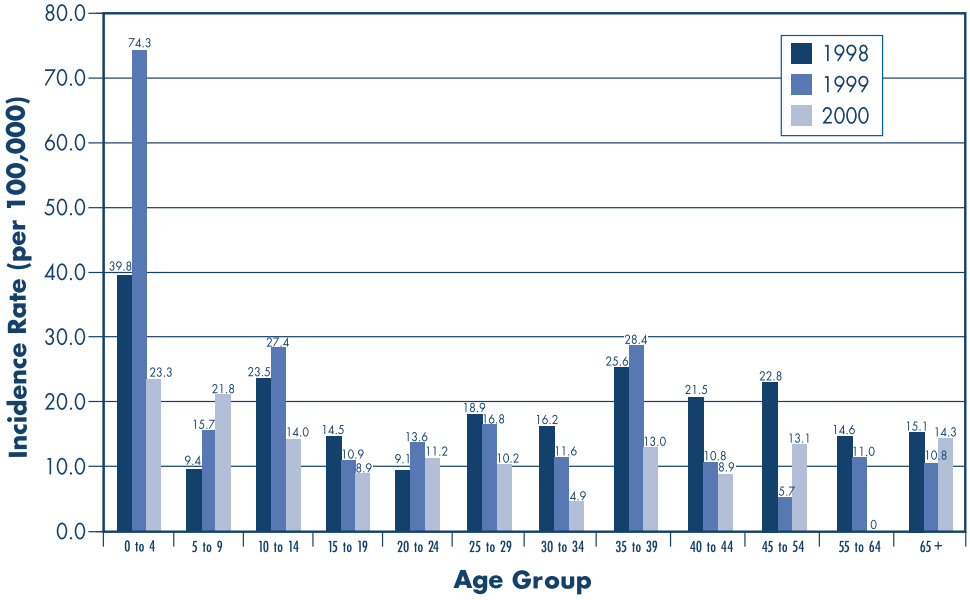
# FOOD- AND WATER-BORNE DISEASE

**Figure 25: Incidence rate (per 100,000 population) of salmonellosis by race/ethnicity, City of Long Beach, 1998-2000.**




Total cases for 1998 = 82 (American Indian=1, Asian/PI=4, Black=20, Hispanic=29, White=17, Unspecified=11)
Total cases for 1999 = 77 (Asian/PI=8, Black=13, Hispanic=29, White=21, Unspecified=6)
Total cases for 2000 = 57 (Asian/PI=8, Black=9, Hispanic=19, White=13, Unspecified=8)
Source: Long Beach Department of Health and Human Services, Epidemiology Program.

**Figure 26: Incidence rate (per 100,000 population) of salmonellosis by age group, City of Long Beach, 1998-2000.**




Total cases for 1998 = 82 (American Indian=1, Asian/PI=4, Black=20, Hispanic=29, White=17, Unspecified=11)
Total cases for 1999 = 78 (Asian/PI=8, Black=13, Hispanic=29, White=21, Unspecified=6)
Total cases for 2000 = 57 (Asian/PI=8, Black=9, Hispanic=19, White=13, Unspecified=8)
Source: Long Beach Department of Health and Human Services, Epidemiology Program.

# BLOOD-BORNE AND SEXUALLY TRANSMITTED DISEASES

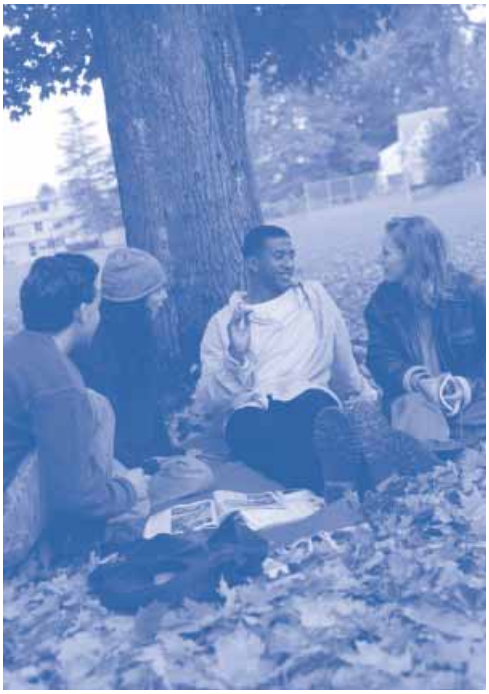
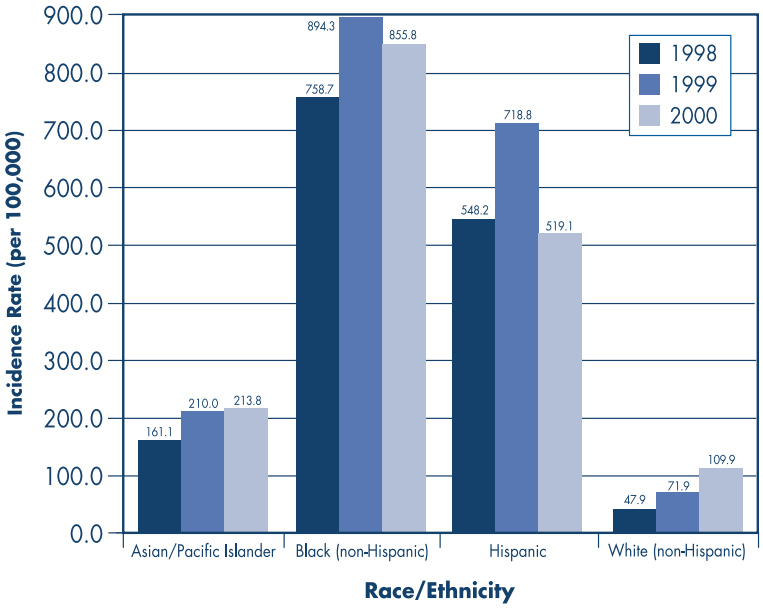
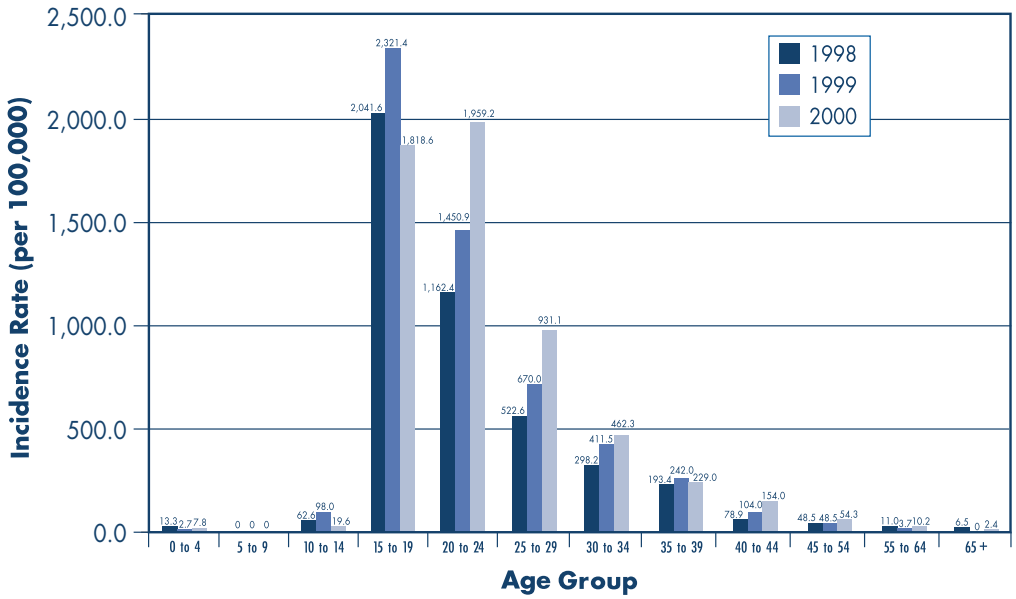


**Figure 27: Incidence rate (per 100,000 population) of chlamydia by race/ethnicity, City of Long Beach, 1998-2000.**



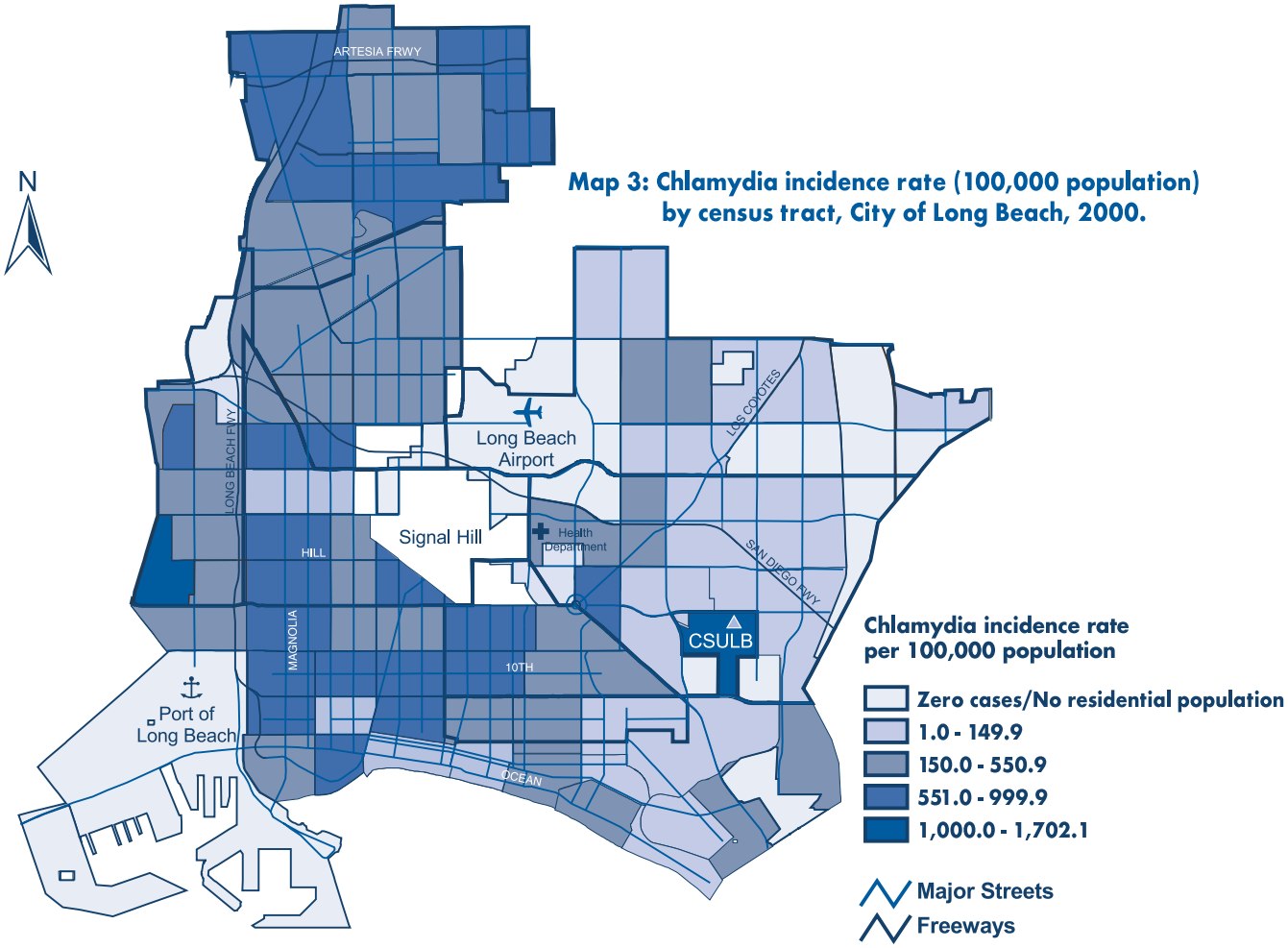

Total cases for 1998 = 1,592 (American Indian=4, Asian/PI=89, Black=431, Hispanic=556, White=102, Unspecified=410)
Total cases for 1999 = 1,898 (American Indian=3, Asian/PI=116, Black=508, Hispanic=729, White=153, Unspecified=388)
Total cases for 2000 = 2,044 (American Indian=1, Asian/PI=129, Black=572, Hispanic=857, White=168, Unspecified=315)
Source: Long Beach Department of Health and Human Services, Epidemiology Program.

**Figure 28: Incidence rate (per 100,000 population) of chlamydia by age group, City of Long Beach, 1998-2000.**



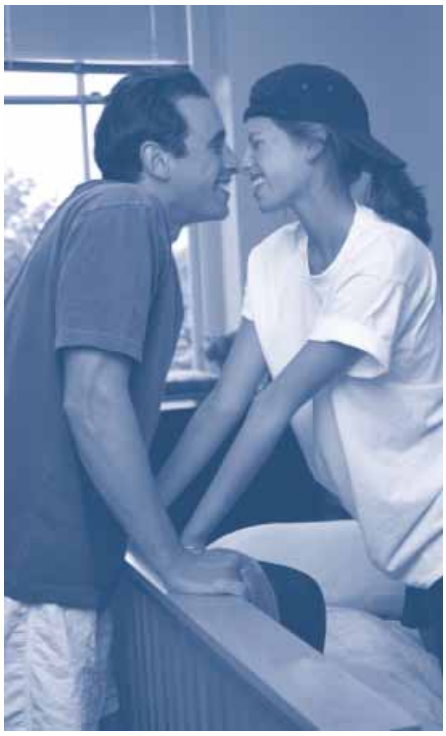

Total cases for 1998 = 1,592 (American Indian=4, Asian/PI=89, Black=431, Hispanic=556, White=102, Unspecified=410)
Total cases for 1999 = 1,898 (American Indian=3, Asian/PI=116, Black=508, Hispanic=729, White=153, Unspecified=388)
Total cases for 2000 = 2,044 (American Indian=1, Asian/PI=129, Black=572, Hispanic=857, White=168, Unspecified=315)
Source: Long Beach Department of Health and Human Services, Epidemiology Program.

# BLOOD-BORNE AND SEXUALLY TRANSMITTED DISEASES

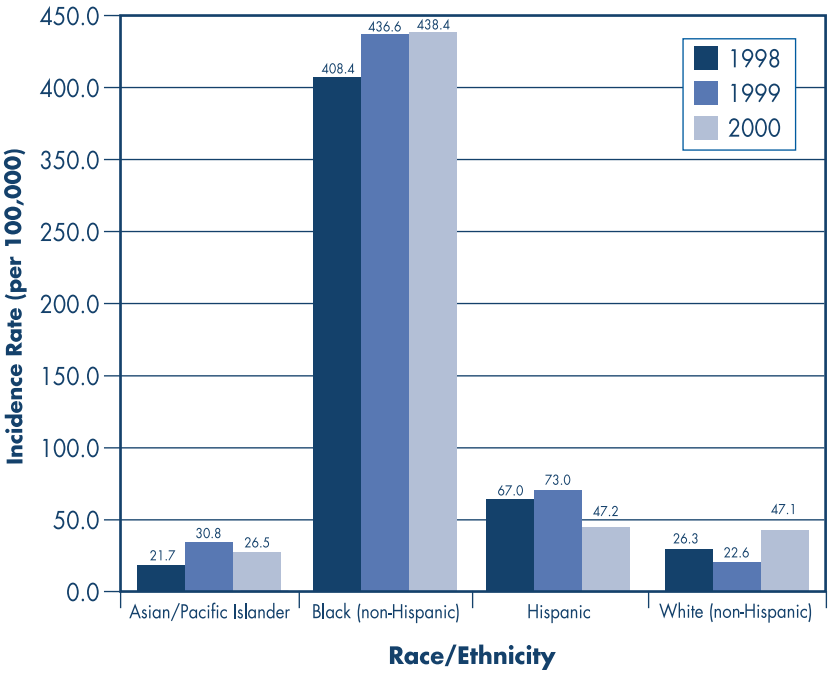



**Map 3: Chlamydia incidence rate (100,000 population) by census tract, City of Long Beach, 2000.**

Source: Long Beach Department of Health and Human Services, Epidemiology Program.

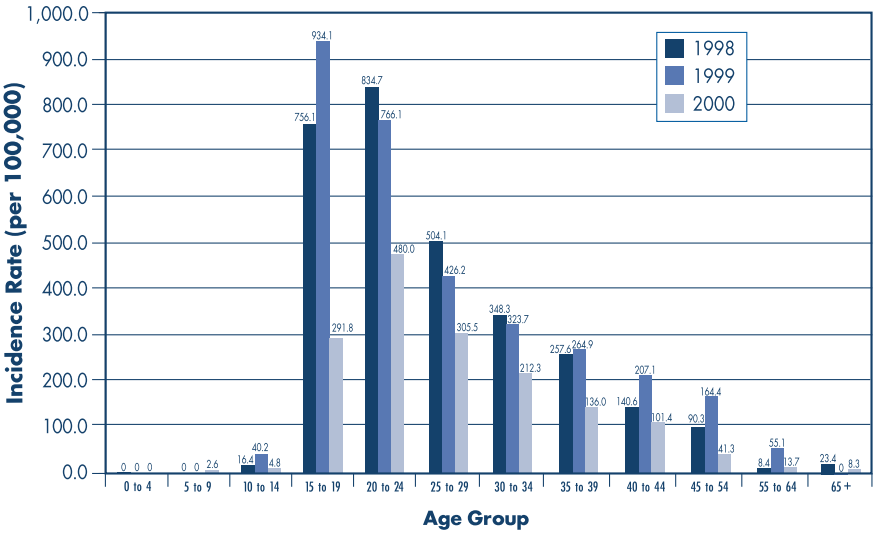


## Figure 29: Incidence rate (per 100,000 population) of gonorrhea by race/ethnicity, City of Long Beach, 1998-2000.



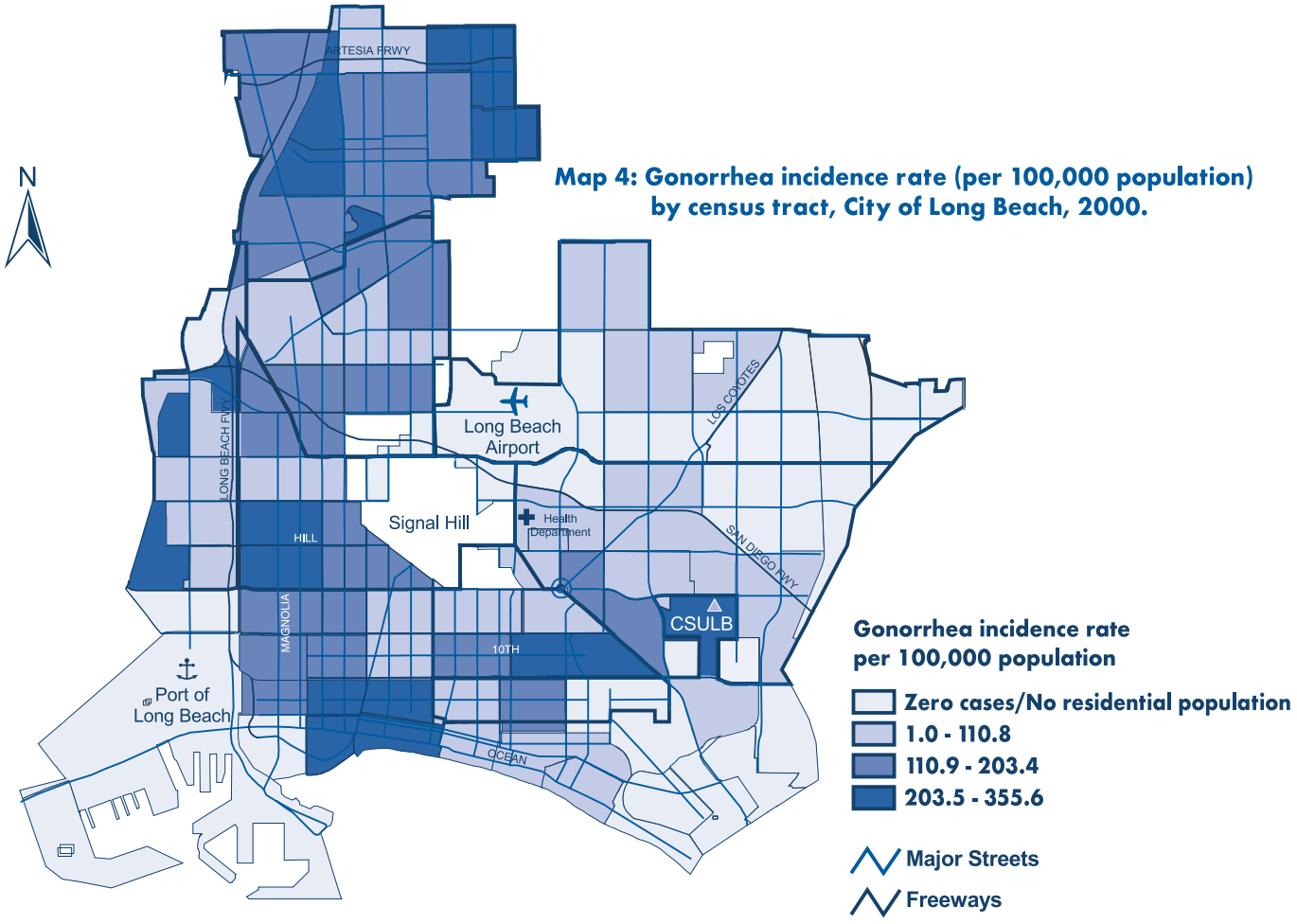

Total cases for 1998 = 541 (Asian/PI=12, Black=252, Hispanic=68, White=56, Unspecified=153)
Total cases for 1999 = 538 (American Indian=1, Asian/PI=17, Black=248, Hispanic=74, White=48, Unspecified=150)
Total cases for 2000 = 576 (Asian/PI=16, Black=293, Hispanic=78, White=72, Unspecified=117)
Source: Long Beach Department of Health and Human Services, Epidemiology Program.

## Figure 30: Incidence rate (per 100,000 population) of gonorrhea by age group, City of Long Beach, 1998 - 2000.




Total cases for 1998 = 541 (Asian/PI=12, Black=252, Hispanic=68, White=56, Unspecified=153)
Total cases for 1999 = 538 (American Indian=1, Asian/PI=17, Black=248, Hispanic=749, White=48, Unspecified=150)
Total cases for 2000 = 576 (Asian/PI=16, Black=293, Hispanic=78, White=72, Unspecified=117)
Source: Long Beach Department of Health and Human Services, Epidemiology Program.

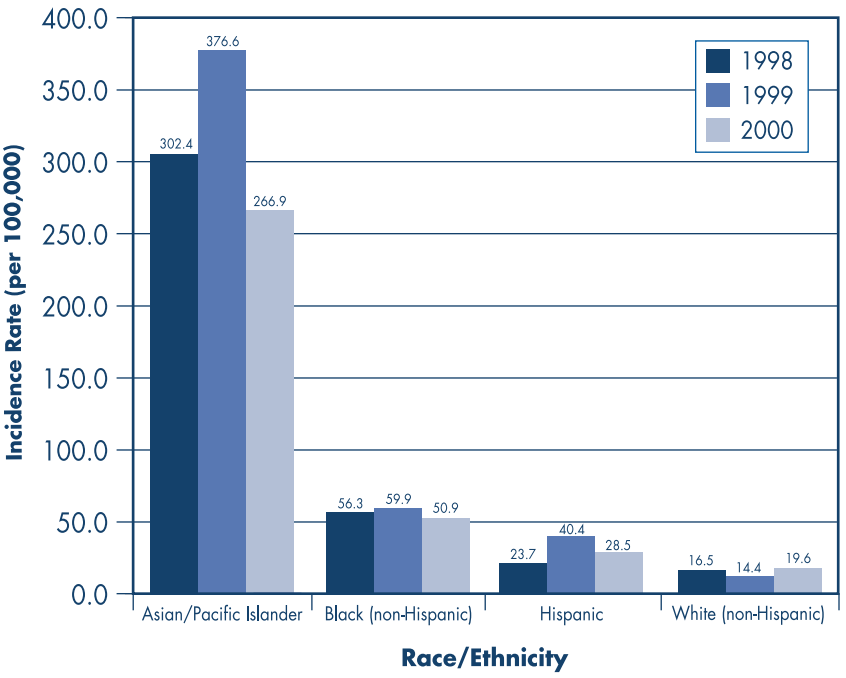
# BLOOD-BORNE AND SEXUALLY TRANSMITTED DISEASES




**Map 4: Gonorrhea incidence rate (per 100,000 population) by census tract, City of Long Beach, 2000.**

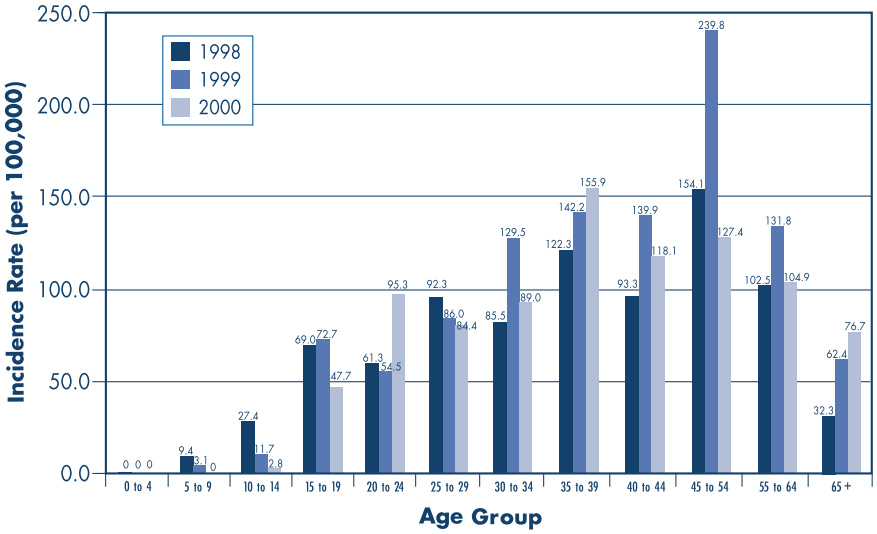
Source: Long Beach Department of Health and Human Services, Epidemiology Program.

**Figure 31: Incidence rate (per 100,000 population) of hepatitis B - carrier by race/ethnicity, City of Long Beach, 1998-2000.**



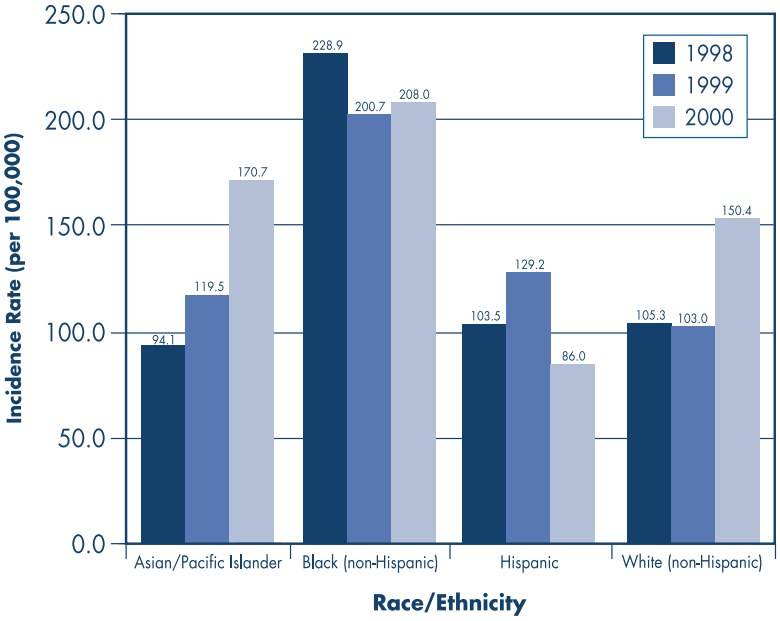

Total cases for 1998 = 303 (Asian/PI=167, Black=32, Hispanic=24, White=35, Unspecified=45)
Total cases for 1999 = 383 (Asian/PI=208, Black=34, Hispanic=41, White=30, Unspecified=70)
Total cases for 2000 = 351 (American Indian=1, Asian/PI=161, Black=34, Hispanic=47, White=30, Unspecified=78)
Source: Long Beach Department of Health and Human Services, Epidemiology Program.

**Figure 32: Incidence rate (per 100,000 population) of hepatitis B - carrier by age group, City of Long Beach, 1998-2000.**



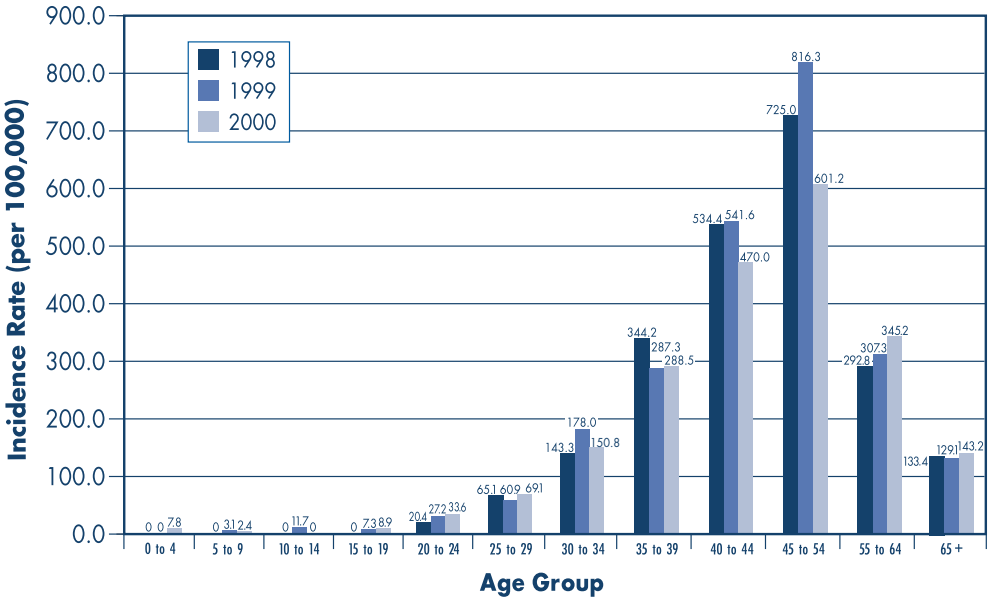

Total cases for 1998 = 303 (Asian/PI=167, Black=32, Hispanic=24, White=35, Unspecified=45)
Total cases for 1999 = 383 (Asian/PI=208, Black=34, Hispanic=41, White=30, Unspecified=70)
Total cases for 2000 = 351 (American Indian=1, Asian/PI=161, Black=34, Hispanic=47, White=30, Unspecified=78)
Source: Long Beach Department of Health and Human Services, Epidemiology Program.

**Figure 33: Incidence rate (per 100,000 population) of hepatitis C - carrier by race/ethnicity, City of Long Beach, 1998-2000.**




Total cases for 1998 = 768 (American Indian=1, Asian/PI=52, Black=130, Hispanic=105, White=224, Unspecified=253)
Total cases for 1999 = 806 (American Indian=3, Asian/PI=66, Black=114, Hispanic=131, White=219, Unspecified=273)
Total cases for 2000 = 860 (American Indian=4, Asian/PI=103, Black=139, Hispanic=142, White=230, Unspecified=242)
Source: Long Beach Department of Health and Human Services, Epidemiology Program.

**Figure 34: Incidence rate (per 100,000 population) of hepatitis C - carrier by age group, City of Long Beach, 1998-2000.**




Total cases for 1998 = 768 (American Indian=1, Asian/PI=52, Black=130, Hispanic=105, White=224, Unspecified=253)
Total cases for 1999 = 806 (American Indian=3, Asian/PI=66, Black=114, Hispanic=131, White=219, Unspecified=273)
Total cases for 2000 = 860 (American Indian=4, Asian/PI=103, Black=139, Hispanic=142, White=230, Unspecified=242)
Source: Long Beach Department of Health and Human Services, Epidemiology Program.

# AIDS

## HIV/AIDS Epidemic Timeline

### 1981-1983

- June 1981, CDC report suggests the possibility of a cellular-immune dysfunction among five gay men in Los Angeles, California diagnosed with PCP.
- In 1982, 827 cases of what will be known as AIDS are reported to the CDC.
- In December 1982, AIDS from a blood transfusion is documented. Injection drug users, gay men and others considered at high risk for AIDS are urged not to donate blood.
- In May 1983, Frenchman Luc Montagnier at the Pasteur Institute isolates the AIDS-causing retrovirus to be known as Human Immunodeficiency Virus (HIV).
- Through 1983, 2,952 cumulative AIDS cases are reported to the CDC.
- Through 1983, 17 cumulative AIDS cases are reported in Long Beach. All 17 cases are deceased by the end of 1983.

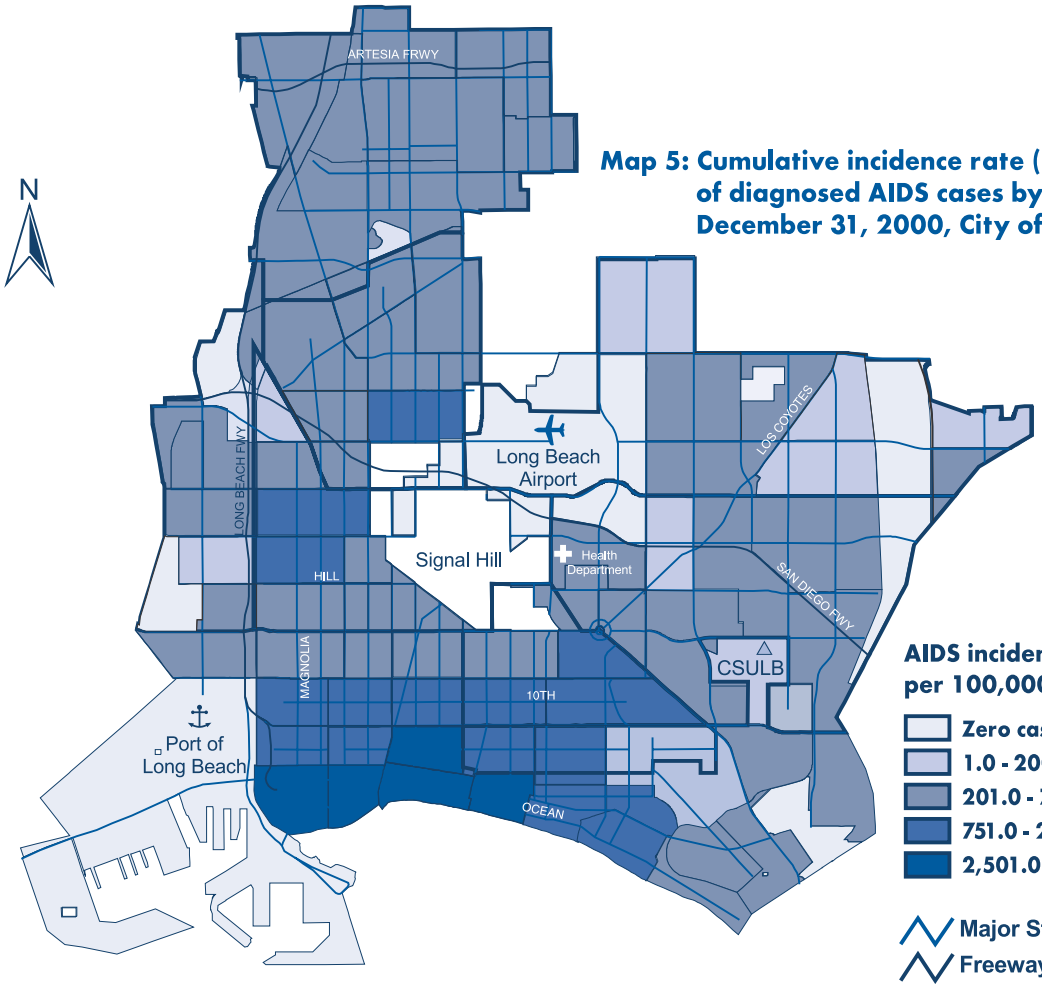
### 1984-1986

- In 1984, 4,642 new AIDS cases are reported to the CDC.
- In March 1995, the FDA approves the first HIV antibody test.
- In April 1985, the first international AIDS conference is held in Atlanta, Georgia.
- In July 1985, Rock Hudson announces that he has AIDS.
- In October 1986, U.S. Surgeon General C. Everett Koop issues a report calling for public health measures and sex education to combat the AIDS epidemic.
- In 1986, the first panel of the Names Project AIDS Memorial Quilt is created.
- Through 1986, 28,593 cumulative AIDS cases are reported to the CDC.
- In 1985, the City of Long Beach Health Department begins HIV testing.
- Through 1986, 225 cumulative AIDS cases are reported in Long Beach. Of these, 82% are White males.

### 1987-1989

- In 1987, 20,413 new AIDS cases are reported to the CDC.
- In March 1987, the FDA approves AZT, the first anti-HIV drug.
- In May 1987, President Ronald Reagan speaks to the Nation for the first time about AIDS.
- In June 1987, the United States bars HIV infected immigrants and travelers from entering the country.

# AIDS




**Map 5: Cumulative incidence rate (per 100,000 population) of diagnosed AIDS cases by census tract through December 31, 2000, City of Long Beach.**

Source: Long Beach Department of Health and Human Services, HIV/AIDS Epidemiology Program.
Note: Data provisional due to reporting delays.

- In October 1987, journalist Randy Shilts publishes a chronicle on the AIDS epidemic called And the Band Played On.
- In 1988, the Office of AIDS Research is established under the auspices of the National Institute of Health.
- In November 1988, the FDA approves alpha interferon, the first drug approved specifically for treating Kaposi's sarcoma.
- In June 1989, the FDA approves aerosol pentamidine for the prevention of PCP.
- Through 1989, 117,781 cumulative AIDS cases are reported to the CDC.
- In 1988, the AIDS Prevention and Follow-up Center (APFC) pilot sites (later renamed Early Intervention Program) was established in the City of Long Beach and Santa Clara County, California utilizing federal funds. The goals were to provide emotional support, behavior

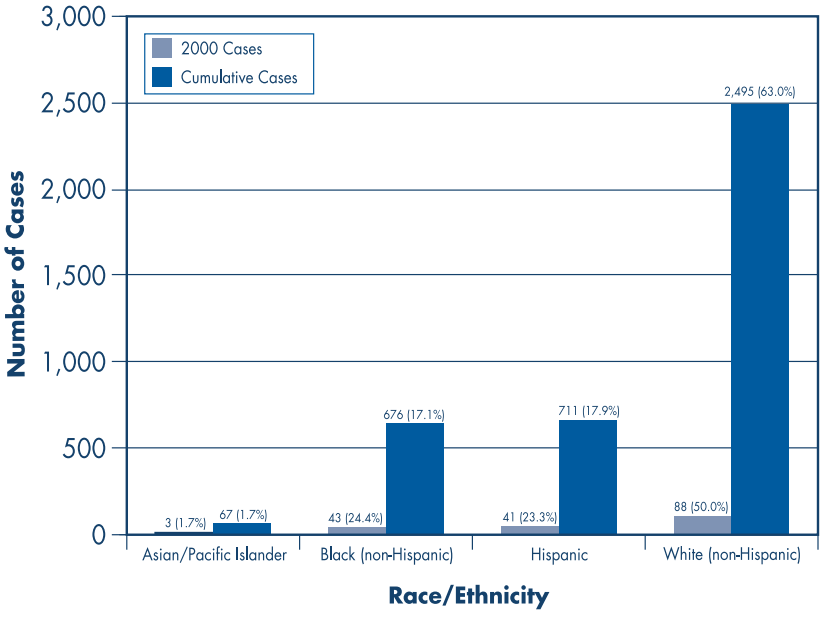
change, and education to HIV positive clients in an effort to reduce the spread of new infections.

- In 1988-89, the AIDS Drug Assistance Program (ADAP) was established to assist people with HIV and AIDS in obtaining medications.
- Through 1989, 859 cumulative AIDS cases are reported in Long Beach. MSM transmission is the most prevalent mode of transmission comprising 84% of all reported cases.

## 1990-1992

- In 1990, 43,292 new AIDS cases are reported to the CDC.
- In April 1990, Ryan White dies at the age of 18. He had received an HIV-tainted blood transfusion five years earlier. In August, Congress authorizes funding for the Ryan White Comprehensive AIDS Resources Emergency Act of 1990. This Act is a major source of federal funding for HIV/AIDS programs.
- In 1991, nearly a decade into the AIDS epidemic, the World Health Organization (WHO) announces that 10 million people worldwide are infected with HIV.
- In November 1991, Magic Johnson announces that he is HIV-positive.
- In July 1992, researchers release reports of the benefits of using anti-HIV drugs in combination.
- In December 1992, the CDC adopts a new set of AIDS-defining conditions after activists charge that the agency is ignoring the symptoms of IDUs and women. This new set of conditions results in a new "AIDS case definition" and causes a surge in the number of new AIDS cases reported in 1993.

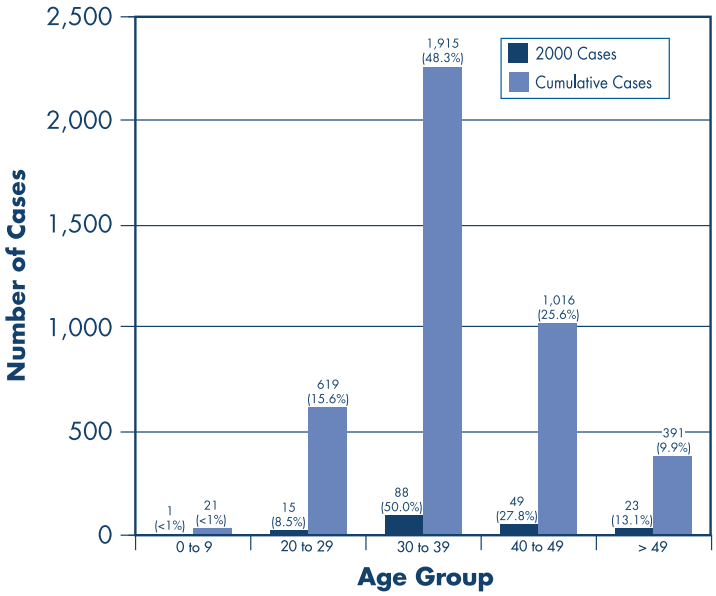
**Figure 35: Number of diagnosed AIDS cases by race/ethnicity, City of Long Beach, 2000.**




Total cases = 176
Total cumulative cases = 3,962
Percentages may not equal 100% due to rounding.
Source: Long Beach Department of Health and Human Services, HIV/AIDS Epidemiology Program.

# AIDS

**Figure 36: Incidence of diagnosed AIDS cases by age group, City of Long Beach, 2000.**




Total cases in 2000 = 176
Cumulative cases through 2000 = 3,962
Percentages may not equal 100% due to rounding.
Source: Long Beach Department of Health and Human Services, HIV/AIDS Epidemiology Program.

- Through 1992, 253,448 cumulative AIDS cases are reported to the CDC.
- Through 1992, 1,935 cumulative AIDS cases are reported in Long Beach. Forty-eight percent of these cases are between the ages of 30-39 years. Infection among these individuals most likely occurred during their 20's.

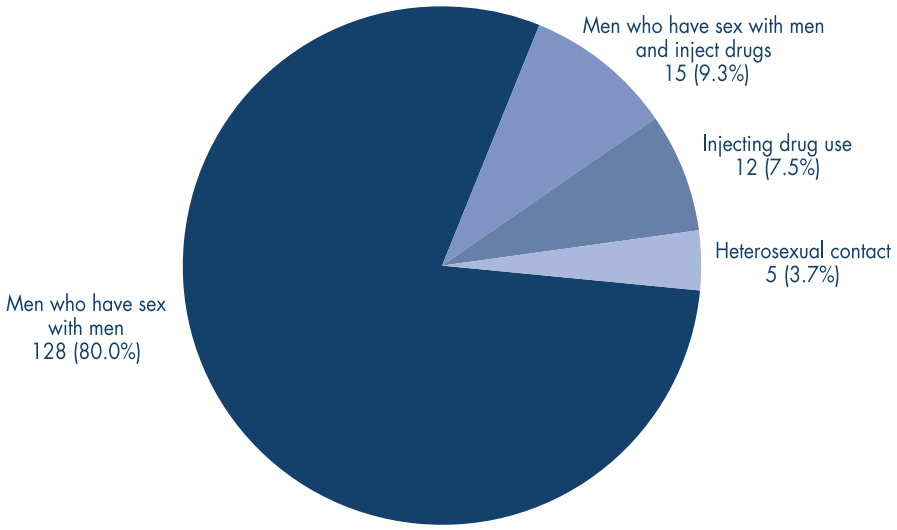
## 1993-1995

- In 1993, 107,716 new AIDS cases are reported to the CDC.
- In 1994, the U.S. Public Health Service recommends the use of AZT to help reduce the chances of mother-to-child transmission of HIV during pregnancy and birth.
- In 1994, AIDS becomes the leading cause of death among Americans between the ages of 25 and 44.
- In January 1995, researchers George Shaw, MD and David Ho, MD working independently, announce that HIV does not lie dormant in the body after initial infection, contrary to earlier beliefs.
- In December 1995, the FDA approves saquinavir, the first protease inhibitor to be prescribed to HIV patients.
- Through 1995, 513,486 cumulative AIDS cases are reported to the CDC.
- In 1994, the HIV Prevention Planning Committee was established in Long Beach. This local implementation group meets monthly to discuss the allocation of HIV prevention funds.
- Through 1995, 2,921 cumulative AIDS cases are reported in Long Beach. Blacks and Hispanics account for 31% of all cases.

## 1996-1998

- In 1996, 67,943 new AIDS cases are reported to the CDC.
- In July 1996, combination therapy with the addition of new drug type called protease inhibitors that helps extremely ill patients regain their health is reported at the 11th International AIDS Conference in Vancouver, Canada. These drugs become dubbed "HIV cocktails."
- In April 1996, the City of Long Beach Department of Health and Human Services begins HIV/STD screening through its Mobile Clinic. Outreach services are also provided through the Mobile Clinic by California State University, Long Beach.
- A February 1997 report states that deaths from AIDS-related complications fell 13% in the first six months of 1996. This is the first significant drop in AIDS-related deaths since 1981. Credit

**Figure 37: Adult/adolescent AIDS diagnosed cases in males by mode of exposure, City of Long Beach, 2000.**




Total cases = 161
Source: Long Beach Department of Health and Human Services, HIV/AIDS Epidemiology Program.

of the drop is given to better treatment for AIDS patients including the development of protease inhibitors and better access to treatment through state and federal programs.

- In June 1998, the U.S. Supreme Court hands down a ruling that states HIV-positive individuals are protected under the American With Disabilities Act.
- At the 12th International AIDS Conference in Geneva in1998, a report is issued warning that an HIV vaccine is at least 15 years away, that drug resistance and side effects are causing patients not to follow prescribed regimens, and that prevention campaigns in the United States and other developed nations are failing.
- AIDS falls out of the 10 leading causes of death among all Americans, but continues to be among the five leading causes of death among Americans ages 25-44 years.
- Through 1998, 688,200 cumulative AIDS cases are reported to the CDC.
- In 1998, the Long Beach Early Intervention Program celebrated its 10-year anniversary. By 1998, over 350 individuals received care through the program.
- Through 1998, 3,578 cumulative AIDS cases are reported in Long Beach. Whites account for nearly two-thirds of all cases.

## 1999-2001

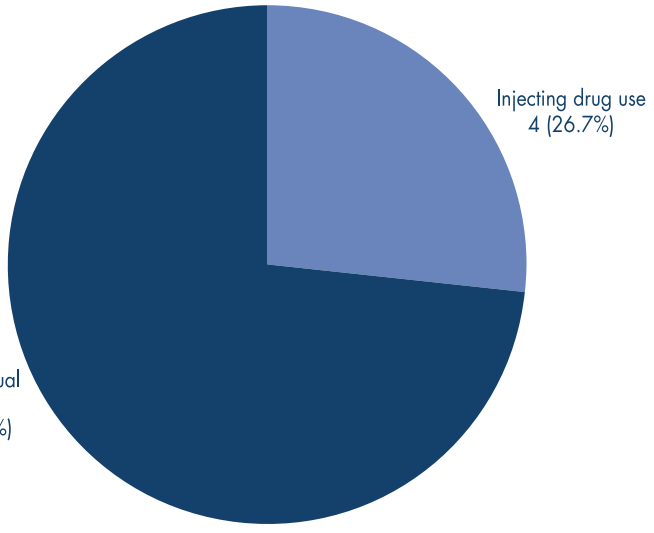
- In 1999, 42,697 new AIDS cases are reported to the CDC.
- In May 1999, the WHO announces that AIDS is the most deadly infectious disease, overtaking tuberculosis deaths, and is the fourth leading cause of death worldwide.
- In August 1999, the City of Long Beach Department of Health and Human Services launched the "The Beach Mobile," a new mobile clinic. The Mobile Clinic provides HIV/STD testing and counseling throughout Long Beach in areas with populations at high risk for infection.
- In September 1999, research teams working independently announce they have discovered cases of newly infected individuals in the United States and Europe who have highly multidrug-resistant forms of the virus.
- As of June 30, 2000, 753,907 cumulative cases have been reported in the United States. The CDC estimates that there are approximately 40,000 new HIV infections in the U.S. each year.

# AIDS


- New York, California, Florida, Texas, and New Jersey have the highest number of cumulative AIDS cases among reporting States, respectively.
- In the year 2001, the CDC estimates that there are between 800,000 and 900,000 people currently living with HIV in the United States.
- Through 2001, 4,061 cumulative AIDS cases are reported in Long Beach. Of these, 2,396 (59%) are deceased.
- In Long Beach, the cumulative number of pediatric AIDS cases reported through 2001 is 11. The main mode of transmission among these cases are mothers with or at risk for HIV infection.
- Females account for 6% of the cumulative AIDS cases reported in Long Beach. The main modes of transmission are heterosexual contact and IDU comprising 53% and 38% of the cases, respectively.
- Through 2001, MSMs remains the most common mode of transmission, making up 81% of all reported AIDS cases in Long Beach among males and 76% of cumulative cases.

*AIDS Timeline Sources:*
Centers for Disease Control and Prevention, MMWR, 2001 Jun 1; 50(21); 430-434. • The AIDS Epidemic at 20 Years: A View from America. • The Henry J. Kaiser Family Foundation, 2001. • HIV Plus, June/July 2001. • City of Long Beach Department of Health and Human Services, HIV/AIDS Epidemiology Program. • City of Long Beach Department of Health and Human Services, Preventive Health Services Clinic.

**Figure 38: Adult/adolescent AIDS diagnosed cases in females by mode of exposure, City of Long Beach, 2000.**

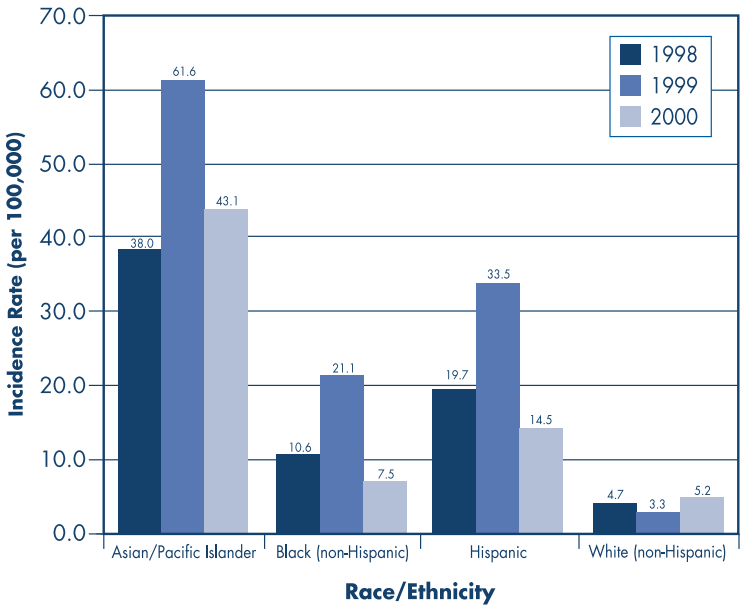



Total cases = 15
Source: Long Beach Department of Health and Human Services, HIV/AIDS Epidemiology Program.

*All AIDS data provisional due to reporting delays.

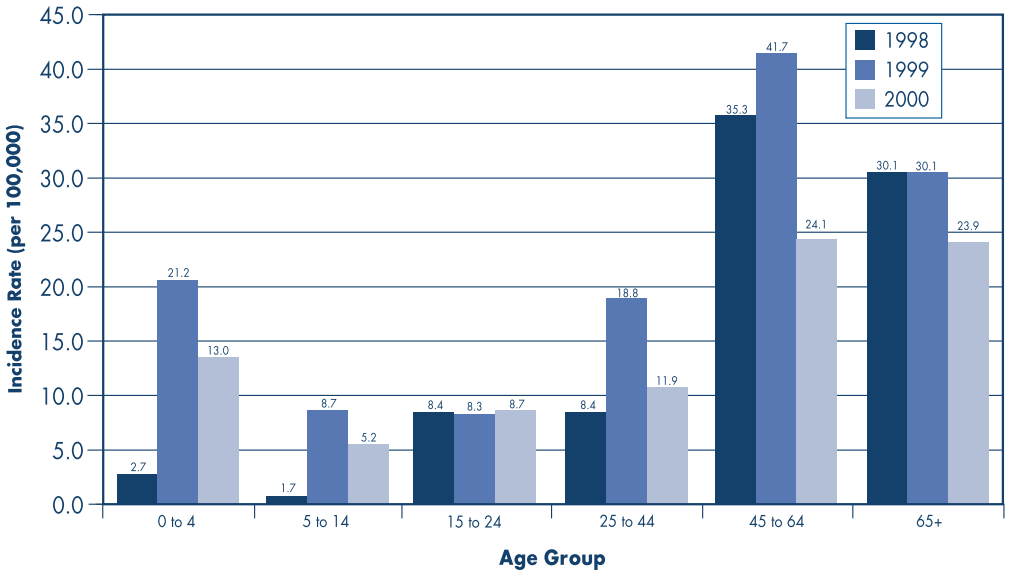
# TUBERCULOSIS

**Figure 39: Incidence rate (per 100,000 population) of tuberculosis by race/ethnicity, City of Long Beach, 1998-2000.**




Total cases for 1998 = 57 (Asian/PI=21, Black=6, Hispanic=20, White=10)
Total cases for 1999 = 88 (American Indian=1, Asian/PI=34, Black=12, Hispanic=34, White=7)
Total cases for 2000 = 63 (Asian/PI=26, Black=5, Hispanic=24, White=32)
Source: Long Beach Department of Health and Human Services, Epidemiology Program.

**Figure 40: Incidence rate (per 100,000 population) of tuberculosis by age group, City of Long Beach, 1998-2000.**



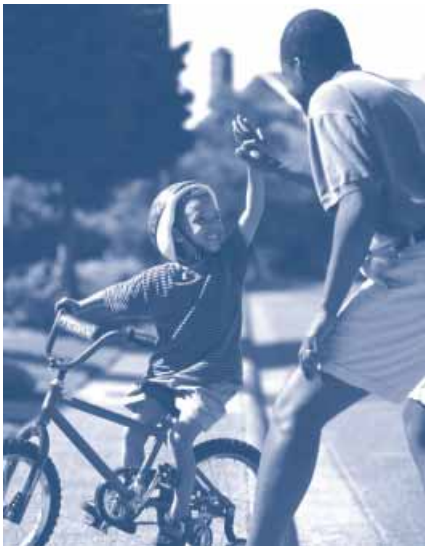

Total cases for 1998 = 57
Total cases for 1999 = 88
Total cases for 2000 = 63
Source: Long Beach Department of Health and Human Services, Epidemiology Program.

# TECHNICAL NOTES

## Sources of Data

The source documents for the natality and mortality data were the certificates of live birth and death, which were received by the City of Long Beach Department of Health Services. Birth and death data presented in this report reflect all births and deaths, which occurred to Long Beach residents. The City of Long Beach participates with other States and counties so that residents who give birth or die outside of the City can be included in the Long Beach figures. The information in this report can be considered official data unless otherwise stated.

Various sources were used to compile this report. Demographic data for the City of Long Beach are taken from the U.S. Census Bureau (1990 and 2000). The birth, death and morbidity data are obtained from the Automated Vital Statistics System. The City of Long Beach, HIV/AIDS Epidemiology Program and Disease Intervention Specialists from the California Department of Health Services (DHS), STD Control Branch at the Health Department provides AIDS and syphilis data, respectively.



Vital statistics events (births and deaths) are registered at the City of Long Beach Department of Health and Human Services and sent to the State of California Department of Health Services, Center for Health Statistics, Office of Health Information and Research, which officially counts events occurring to Long Beach residents, including events that happen in other jurisdictions among Long Beach residents. The accurate compilation of official vital statistics data by the DHS may result in delays before final summaries can be released to each health jurisdiction.

The communicable disease data are based on reports submitted under Title 17, California Code of Regulations (CCR) Section 2500, which requires that all health care providers and laboratories report communicable diseases and selected conditions to local health jurisdictions.

## Cause of Death Classification

The underlying cause of death is determined from the medical certification section of the death certificate, in accordance with procedures established by the National Center for Health Statistics. Codes are assigned from the International Statistical Classification of Diseases and Related Health Problems, (ICD).

## Calculation of Rates

The rates in this report are based on U.S. Census population estimates. In tables, charts or graphs that contain race/ethnicity breakdowns, data for specific categories not given, have either zero cases or very low numbers. Therefore these race/ethnicities are included with all races/ethnicities.

In tables, charts or graphs containing data on births, the race/ethnicity given is the mother's listed on the birth certificate.

According to the Census Bureau, the concept of race reflects self-identification by people according to their race or races, with which they most closely identify. Furthermore, the race categories include both racial and national-origin groups. The following are categorical definitions of the races and national-origin groups.

***White:*** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa. It includes people who indicate their race as "White" or report entries such as Irish, German, Italian, Lebanese, Near Easterner, Arab, or Polish.

***Black or African American:*** A person having origins in any of the Black racial groups of Africa. It includes people who indicate their race as "Black, African Am., or Negro," or provide written entries such as African American, Afro American, Kenyan, Nigerian, or Haitian.

***American Indian or Alaska Native:*** A person having origins in any of the original peoples of North and South America (including Central America) and who maintain tribal affiliation or community attachment. It includes people who classified themselves as described below.

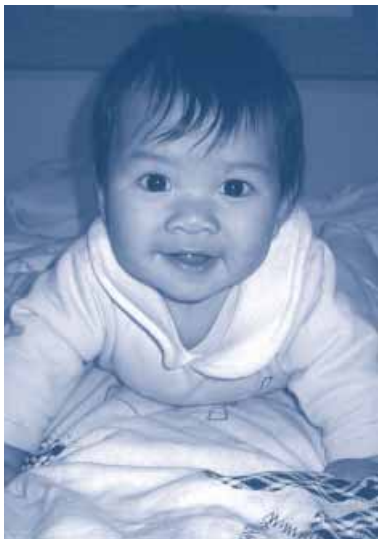
***American Indian:*** Includes people who indicated their race as "American Indian," entered the name of an Indian tribe, or reported such entries as Canadian Indian, French-American Indian, or Spanish-American Indian.

***Alaska Native:*** Includes Eskimos, Aleuts, and Alaska Indians, Arctic Slope, Inupiat, Yupik, Alutiiq, Egegik, and Pribilovian. The Alaska tribes are the Alaskan Athabascan, Tlingit, and Haida.

***Asian:*** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. It includes "Asian Indian," "Chinese," "Filipino," "Korean," "Japanese," "Vietnamese," and "Other Asian." Other Asians include persons having origins Bangladeshi, Bhutanese, Burmese, Indochinese, Indonesian, Iwo Jiman, Madagascar, Malaysian, Maldivian, Nepalese, Okinawan, Pakistani, Singaporean, Sri Lankan, or Other Asian specified and Other Asian, not specified.

***Native Hawaiian and Other Pacific Islander:*** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. It includes people who indicate their race as "Native Hawaiian," "Guamanian or Chamorro," "Samoan," and "Other Pacific Islander."

***Some other race:*** Includes all other responses not included in the "White," "Black or African American," "American Indian or Alaska Native," "Asian," and "Native Hawaiian and Other Pacific Islander" race categories.



***Two or more races:*** Persons identifying themselves with two or more races. "Two or more races" refers to combinations of two or more of the following race categories:

1. White
2. Black or African American
3. American Indian and Alaska Native
4. Asian
5. Native Hawaiian and Other Pacific Islander
6. Some other race

*Note: Race/ethnicity based on U.S. Bureau of the Census definitions.*

If you have any questions or comments about the data contained in this report, please call the City of Long Beach Department of Health and Human Services at (562) 570-4382. For more information on disease reporting, please call the Health Department's Epidemiology Program at (562) 570-4302.

**Historical data highlighted in this report is for Long Beach only.**

# REFERENCES


1. Los Angeles Times, 1999.
2. Centers for Disease Control and Prevention. MMWR, 1999.
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13. City of Long Beach Department of Health and Human Services, HIV/AIDS Epidemiology Program.
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15. City of Long Beach Department of Health and Human Services, Immunization Program.
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17. City of Long Beach Department of Health and Human Services. Public Health Reports. 1946, 1947, 1950.


# GLOSSARY

**Adolescent Mothers:** Mothers younger than 18 years of age.

**Birthrate:** Number of live births reported during a specified period of time, usually one year, divided by the population of the area at midpoint of the time period. Reported per 1,000 population.

**Census Tract:** A small, relatively permanent statistical subdivision of a state, county or city. Designed to be relatively homogeneous units with respect to population characteristics, economic status, and living conditions at the time of establishment, census tracts average about 4,000 inhabitants. In 2000, Long Beach included all or part of 106 tracts.

**Centers for Disease Control and Prevention (CDC):** Federal agency responsible for promoting public health and the vision of Healthy People in a Healthy World. The CDC is part of the U.S. Department of Health and Human Services and the U.S. Public Health Service.

**Country of Origin:** Country in which a person lived and probably held citizenship during the early years of life.

**Crude Death Rate:** The number of deaths during a specified period time, usually one year, divided by the population at the midpoint of that time period. Reported per 1,000 population.

**Early Prenatal Care:** Prenatal care beginning in the first trimester of pregnancy.

**Fecal/Oral Route:** Transmission of infection usually due to fecal contamination of an object that has oral contact. Such objects often include hands, toys (as in the case of small children), and food preparation utensils. This type of transmission can be prevented by good hygiene, including proper hand washing after using the restroom.

**Fetal Death:** A death at 20 or more weeks gestation identified by the lack of signs of life at delivery. These signs of life include breathing, heartbeat, pulsating umbilical cord, or definite movement of voluntary muscles.

**Fetal Death Rate:** The number of fetal deaths during a specified period of time, divided by the number of live births plus fetal deaths during the same period. Reported per 1,000 births.

**Incidence:** The number of new cases occurring during a specified period of time divided by the number of people at risk, usually the entire population at the midpoint of the time period.

**Infant Mortality Rate:** The number of deaths under one year of age divided by the number of live births in the same year. Reported by 1,000 live births.

**Late Prenatal Care:** Prenatal care which begins after the first trimester of pregnancy or no prenatal care at all.

**Low Birthweight:** Birthweight less than 2,500 grams or 5.5 pounds for live births.

**Median:** The median divides the distribution into two equal parts, one having values above the median, the other having values below the median.

**Peri-natal Transmission:** Transmission of infection from mother to unborn child. Some infections that may be transmitted in this way include measles, chicken pox, hepatitis B, HIV, and syphilis.

**Prevalence:** The number of cases, new and ongoing, present in the population divided by the total population. This measure highlights conditions that are long in duration.

**Unintentional Injury:** Physical infliction induced by an external cause; includes injuries or deaths caused by unanticipated events such as motor vehicle crashes or falls.

# PUBLICATIONS

*The City of Long Beach Department of Health and Human Services provides the following publications to various sectors of the community throughout the year.*

***Breastfeeding Gazette:***
Published by the Women, Infants, and Children (WIC) Program on a quarterly basis, this newsletter is designed as an informative piece for breastfeeding mothers.

***Child Health and Disability Prevention (CHDP) Newsletter:***
This quarterly publication is aimed at providing CHDP providers, public and social services workers, and employees of other agencies that provide services to children from low income families, with updates, case histories, and resources related to child health issues.

***City of Long Beach Department of Health and Human Services Overview:***
This publication highlights the comprehensive array of public health and social services activities the Health Department provides to the Long Beach community.

***City of Long Beach Health Statistics Report:***
First issued in 1998, this report presents official epidemiological and vital statistics data for use by health care providers, policy makers, educators, and other community members.

***Continuing the Commitment, Community Health Research Study II:***
This May 1999 publication paints a wide-ranging portrait of the health care system in the City of Long Beach and provides a closer examination of the economic, distributional, and sociocultural barriers to health. This report was developed in conjunction with the non-profit hospitals in the city and was prepared by the Long Beach Community Health Council and David C. Sloane, Veverlie Conanat Sloane, Amy Bovankovich, and Elizabeth Gearin.

***Continuum of Care for Homeless Assistance:***
This plan is a living document, updated annually, describing components of a consolidated plan to prevent individuals and families from becoming homeless and to help those who are homeless to become housed and self-sufficient. The plan includes service collaboration of various agencies throughout the City of Long Beach working toward a common goal of ending homelessness.

***Food Safety Bulletin:***
This publication provides food establishments in the City of Long Beach with information on safe food handling practices. It includes updated information on laws affecting food services.

***Comprehensive HIV Plan for Long Beach - Summary of Priorities and Needs Assessment Findings:***
This report, published in April 2000, is intended to help increase the effectiveness of HIV care and prevention providers and funders. It establishes a framework to coordinate HIV care and prevention activities, focusing efforts on effective interventions for the populations most at-risk for HIV infection and on priority needs for HIV affected individuals.

# PUBLICATIONS

***HIV/AIDS Semi-Annual Monitoring Report*** [W]***:***
A semi-annual report that provides data that reflect the statistical monitoring of HIV/AIDS surveillance and reporting activities, aimed at identifying the entire range of HIV infection in Long Beach. This report also includes a profile of a highlighted HIV/AIDS topic.

***Immunization Action Plan:***
This annual plan, developed in conjunction with the IAP Task Force, informs the public about the Health Department's goals and objectives relating to increasing recommended immunizations in the community.

***I.A.P. News:***
This quarterly newsletter advises immunization providers and the public about current schedules and the latest developments in immunizations.

***Maternal, Child, and Adolescent Health Five-Year Action Plan:***
This action plan describes the state of maternal, child, and adolescent health in the City of Long Beach and establishes goals for the next five years. The plan is reviewed and updated, as needed, annually.

***PATHS Newsletter:***
This newsletter, produced twice a year, features peer role model stories promoting the prevention of teen pregnancy, sexually transmitted diseases and HIV.

***Public Health Bulletin*** [W]***:***
A monthly publication on communicable diseases and HIV/AIDS activity in Long Beach, including current and/or emerging public health issues of interest.

***STARS Newsletter:***
This bimonthly newsletter disseminates information on the harmful effects of alcohol and drugs to youth within the City of Long Beach.

***We Are Long Beach:***
This 1998 retrospective report highlights the accomplishments of the City of Long Beach Department of Health and Human Services.

These publications are available by calling (562) 570-4012.


[W] These publications are currently available on the Health Department's Web-Site at www.ci.long-beach.ca.us/health.

# CITY OFFICIALS

## Mayor
Beverly O'Neill

## City Council
District 1: Bonnie Lowenthal
District 2: Dan Baker
District 3: Frank Colonna
District 4: Dennis Carroll
District 5: Jackie Kell
District 6: Laura Richardson
District 7: Tonia Reyes Uranga
District 8: Robert Webb
District 9: Val Lerch

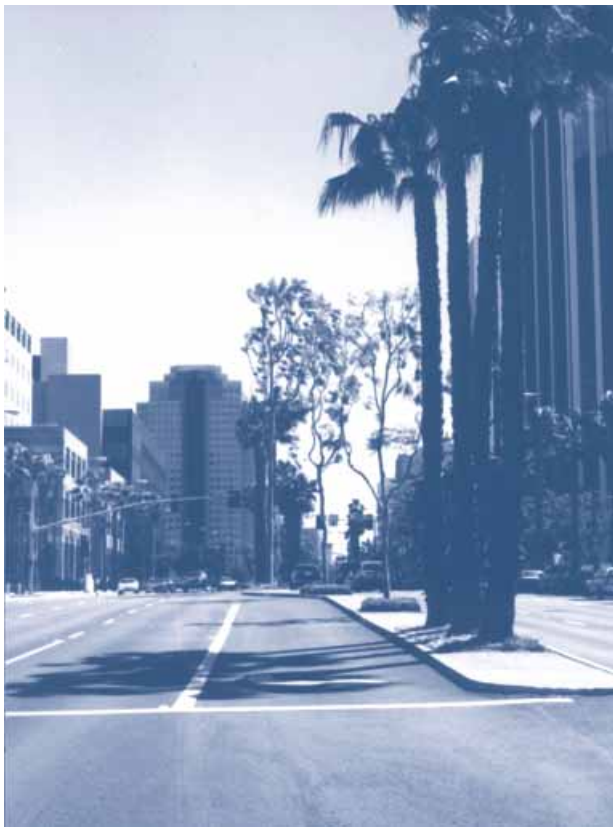
## Acting City Manager
Gerald R. Miller

## City Attorney
Robert E. Shannon

## City Auditor
Gary L. Burroughs

## City Prosecuter
Thomas M. Reeves

## City Clerk
Larry Herrera




"Iowa by the Sea" by mural artist Carlos Ortiz, is one of the historical areas suggested for interpretation on the proposed Victory Park History Walk, a project of the Leadership Long Beach Class of 2002.

# CITY OF LONG BEACH DEPARTMENT OF HEALTH AND HUMAN SERVICES

## Director

Ronald R. Arias, MPA

## City Health Officer

Darryl M. Sexton, MD


## Human and Social Services Bureau

*Manager:* Corinne Schneider
*Rehabilitation Services Officer:* Clarissa Manuel

## Public Health Bureau

*Manager:* Theresa Marino
*Nursing Services Officer:* Pamela Shaw, PHN
*Nutrition Services Officer:* Judy Ogunji, RD
*Laboratory Services Officer:* Bruce Fujikawa, DrPH

## Animal Control Bureau

*Manager:* Roger Hatakeyama

## Environmental Health Bureau

*Manager:* Don Cillay
*Hazardous Waste Operations Officer:* Jeff Benedict

## Preventive Health Bureau

*Manager:* Nettie DeAugustine
*Prevention Services Officer:* Meredith Cagle

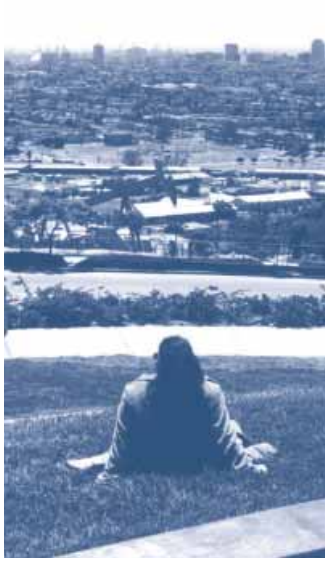
## Support Services Bureau

*Manager:* S. Michael Johnson
*Financial Services Officer:* David Honey

## Physician Services

Occupational Health Services Officer: Irene Grace, MD

# CREDITS



## City of Long Beach Health Statistics Report and Selected Photography

*Prepared by*
Hanan Obeidi

## Special Assistance by

Tanvi Shah

## Graphic Design and Production by

Espie Graphics

## Special Thanks to

The City of Long Beach Department of Health and Human Services Epidemiology Committee

## Preventive Health Bureau, Epidemiology and Vital Records Program

| | |
|---|---|
| Nettie DeAugustine | *Preventive Health Bureau Manager* |
| John Holguin | *Epidemiologist Supervisor* |
| Julie Atkinson, RN | *Epidemiologist* |
| Bettina Brockmann | *Vital Records Registrar* |
| Michael Davis | *HIV/AIDS Epidemiology Coordinator* |
| Terri Hays | *Vital Records Registrar* |
| Christina Kau | *Data Manager* |
| Sarady Kong | *AVSS Coordinator* |
| Hanan Obeidi | *Epidemiology Analyst* |
| Tamara Purnell | *HIV/AIDS Epidemiology Assistant* |
| Amanda Valdez | *Vital Records Clerk* |

## Contact Information

| | |
|---|---|
| *General Information* | (562) 570-4000 |
| *TDD* | (562) 570-4346 |
| *Internet Website* | http://www.ci.long-beach.ca.us/health |
| *Main Facility Address* | 2525 Grand Avenue, Long Beach, CA 90815 |

This information is available in alternative format by request to Michael Johnson at (562) 570-4012.

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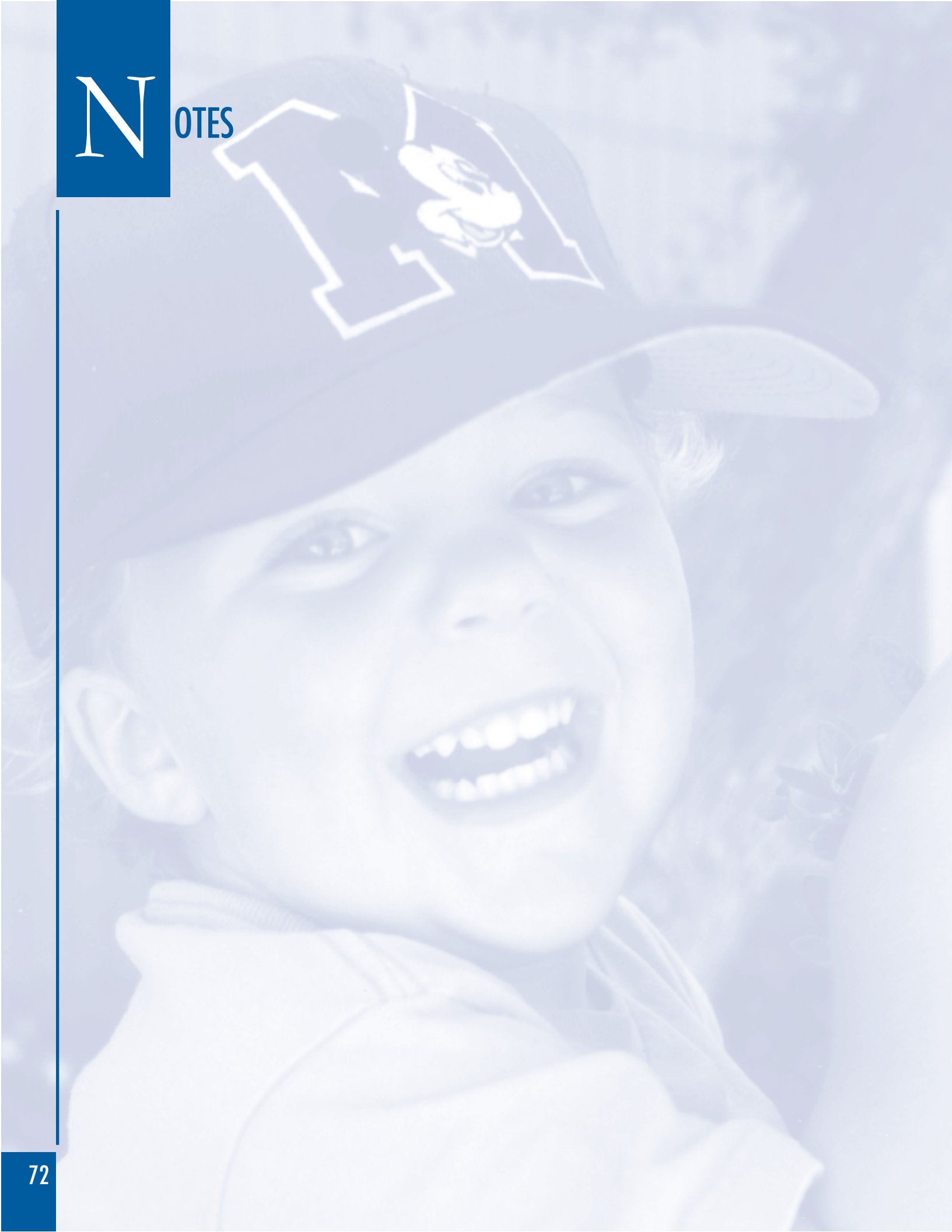

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